PARTICIPANT APPLICATION AND HEALTH HISTORY

To be completed by the participant or parent/legal guardian/caregiver

Participant: ____

DOB: ________ Age: ________ Height: ________ Weight: ________ Gender: M F

Address: ____

Home Phone: ____________________ E-mail: ____________________________________

Work Phone: _____________________ Cell Phone: __________________________________

Alternate Phone (specify): ____

Employer/School: ____

Occupation: ____

Parent/Legal Guardian/Caregiver: ____

Address (if different from above): ____

Phone (if different from above): ____

How did you hear about the program?: ____

HEALTH HISTORY

Diagnosis: ___________________________ Date of Onset: ___________________________

Please indicate current or past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

MEDICATIONS (include prescription & over-the-counter; name, dose, and frequency)

____

____

____

____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed)
PHYSICAL FUNCTION (i.e. mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

____

____

____

____

PSYCHO/SOCIAL FUNCTION (i.e. work/school including grade completed, leisure interests, relationships, family structure, support systems, companion animals, fears/concerns, etc.)

____

____

____

____

GOALS (as they relate to participation in therapeutic riding)

____

____

____

____

AVAILABILITY FOR PARTICIPATION (days & times; please be as specific as possible)

____

____

____

PROGRAMS OF INTEREST (check all that apply):

☐ Therapeutic Riding ☐ Speech Therapy (hippotherapy) ☐ Summer Camp

AGREEMENT FOR RELEASE, WAIVER OF LIABILITY AND INDEMNIFICATION COMMITMENT

The undersigned, in consideration for the right to participate in Horseback Riding Activities at Great and Small, Inc., located at 17320 Moore Road, Boyds, MD 20841 ("Great and Small"), does hereby execute this Agreement for Release, Waiver of Liability and Indemnification Commitment ("Agreement"), and represents and agrees as follows:

1. I fully understand that horse riding activities are by their nature very dangerous activities. Horseback riding is classified as a rugged adventure recreational sport activity and there are numerous obvious and non-obvious inherent risks always present in such activity despite all safety precautions. The term "Horseback Riding Activities" as used herein includes all riding and handling of horses, ponies, mules, or donkeys, whether mounted or on the ground, including but not limited to giving or taking lessons, working in any way with horses, viewing or volunteering as well as all activities associated with boarding one's horse at Great and Small.

2. I understand that in any Horseback Riding Activity I and/or my horse may be injured as a result of my negligence, the negligence of others, or due to fault of no one, and that horses, even when well trained, can be unpredictable and difficult to control.

3. I understand that, upon mounting a horse, the rider is in primary control of the horse. I shall be responsible for the safety, of myself, my horse and other persons and their property, and I will take all reasonable precautions to protect against injury when participating in any Horseback Riding Activities.

4. I agree to wear American Society for Testing & Materials/Safety Equipment Institute Approved ("ASTM/SEI") protective headgear and other appropriate riding gear when riding at any Horseback Riding Activity.

5. By my signature below, I, and my assigns and successors, including my insurers, release, exculpate and agree to indemnify and defend all officers, directors, owners, agents, employees and representatives of any type of Great and Small, (each collectively a "Release") be against any claim of loss, injury, damage or other harm, of any nature, to the fullest extend permissible by applicable law, to myself, my horse and to third parties as a result of my horse.

6. I, and my assigns and successors, including my insurers, shall bring no claim, demand, action or litigation, of any nature, against any Releasee for any economic or non-economic loss due to bodily injury, death, or property damage sustained by me and/or my minor child associated with any Horseback Riding Activities at Great and Small.

7. This agreement constitutes the entire agreement between the parties regarding this matter and may be modified only by written instrument, executed by both parties. It shall be legally binding upon each of the signatories below. It shall be interpreted according to the laws of the state of Maryland, without any consideration who drafted the Agreement. Any disputes regarding this Agreement shall be resolved in a court in Montgomery County, Maryland. If any provision of this Agreement shall be deemed to be invalid or unenforceable, the remaining provisions shall remain effective to the maximum extent permissible by law. The signatories hereto both waive any right that they may otherwise have to have a trial by jury in the event of any dispute involving this Agreement.

8. I agree to pay reasonable attorneys fees, in addition to other damages, should I or my assigns and successors, including my insurers, breach any part of this Agreement in any way.

9. I have assessed the facilities of Great and Small, Inc. and find them to be acceptable for Horseback Riding Activity. I understand and agree that neither Great and Small nor Great and Small Owners is obligated to maintain the property under this Agreement in any manner.

10. I acknowledge and accept that some of the persons served by, or visiting, Great and Small may have behavioral problems or cognitive or physical limitations that may lead to, or increase, the possibility of injury to persons or property, and I knowingly assume all such risks.

READ CAREFULLY BEFORE SIGNING. THIS IS A RELEASE OF YOUR RIGHTS.

______________________________	______________________________
Signature of Participant	Print Name of Participant
______________________________	______________________________
Signature of Parent/Guardian	Print Name of Parent/Guardian
________________	
Date	
______________________________	______________________________
Emergency Contact Name	Emergency Contact Phone

Authorization for Emergency Medical Treatment

Name:_______________________________ Date of Birth: ___________________________________

Address: ____

City/State/Zip: _______________________________ Phone: __________________________________

Physician: __________________________ Preferred Medical Facility: _______________________________

Health Insurance Company: __________________________ Policy #: ________________________________

Allergies to medications: ____

Current medications: ____

In the event of an emergency, contact:

Name: _________________________ Relation: _________________ Phone: _____________________

Name: _________________________ Relation: _________________ Phone: _____________________

Name: _________________________ Relation: _________________ Phone: _____________________

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Great and Small to: (1) Secure and retain medical treatment and transportation if needed, and (2) Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

☐ **Consent Plan**

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

☐ **Non-Consent Plan**

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services, or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

____

____

Signature:____ Date:______________

Signature of Parent/ Guardian:____________________________ Date:______________

Photo/Video Permission

 I DO

 I DO NOT

Authorize Great and Small**,** a private, non-profit corporation, and its agents, volunteers and employees to photograph/video me while volunteering/participating in the activities at Great and Small. I understand that these photographs/videos may be used in Great and Small's promotional materials, electronic and print publications, and other uses of benefit to the program.

________________________________ ________________________________
Signature Print Name

________________________________ ________________________________
Signature of Parent/Guardian Print Name of Parent/Guardian

____
Date

Date: _________________

Dear Health Care Provider:

Your patient, ____, is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic:
Atlantoaxial Instability – include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic:
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other:
Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical:
Allergies
Cardiac Condition
Blood Pressure Control
Exacerbations of medical conditions (i.e. RA, MS)
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Weight Control Disorders

Psychological:
Animal Abuse
Physical/Sexual/Emotional Abuse
Dangerous to self or others
Fire Settings
Substance Abuse
Thought Control Disorders

Participant's Medical History & Physician's Statement

Participant: ______________________________ DOB: _________ Height: ________ Weight: ________

Address: ____

Diagnosis: ____ Date of Onset: _________________

Past/Prospective Surgeries: ____

Medications: ____

Seizure Type: ___________________________ Controlled: Y N Date of Last Seizure: ______________

Shunt Present: Y N Date of Last Revision: ____

Special Precautions/Needs: ____

Mobility: Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N

Braces/Assistive Devices: ____

For those with Down Syndrome: AtlantoDens Interval X-rays, date: ___________________ Result: + -

Neurologic Symptoms of Atlantoaxial Instability: ____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac/Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic/Balance			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the NARHA center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the NARHA center for ongoing evaluation to determine eligibility for participation.

Name/Title: ____ MD DO NP PA Other ____________

Signature: ____ Date: _____________

Address: ____

Phone: (   ) __________________________ License/UPIN Number: _____________________________

Participants with Down Syndrome

Client Name: ____ Date of Birth: ______________

AtlantoDens Interval X-rays, date: ________________________________ _ Result: positive negative

Neurological Symptoms of Atlantoaxial Instability: ____

A physical examination of ____ on ___________________

did not reveal atlantoaxial instability or focal neurologic disorder.

_________________________________ _________________

Physician Signature Date

____

Physician Name (Printed)