



## PARTICIPANT APPLICATION REGISTRATION

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Participant Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Onset: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: M F

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone: \_\_\_\_\_(h) \_\_\_\_\_(w) \_\_\_\_\_(cell)

Employer/Duty Station \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_(h) \_\_\_\_\_(w) \_\_\_\_\_(cell)

Email: \_\_\_\_\_ Referral Source: \_\_\_\_\_

Telephone: \_\_\_\_\_ How did you hear about **EQUI-VETS**? \_\_\_\_\_

### Participant Health History

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

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

**Medications** (include prescription, over-the-counter; name, dose and frequency, side effects encountered):

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**Describe your abilities/difficulties in the following areas (including assistance required or equipment needed):**

**Physical Function** (mobility skills such as transfers, walking, wheelchair use, driving/bus riding):

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**Psycho/Social Function** (work/school including grade completed, leisure interests, relationship-family structure, support system, companion animals, fears/concerns, etc):

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**Goals** (Why are you applying to participate? What would you like to accomplish?):

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**Dated:** \_\_\_\_\_

\_\_\_\_\_  
**EQUI-VETS Participant**



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  
Coxarthrosis  
Cranial Defects  
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 Coed/Hydromyelia

**OTHER**

Indwelling Catheters/Medical Equipment  
Medications - i.e. Photosensitivity  
Poor Endurance  
Skin Breakdown

**MEDICAL/PSYCHOLOGICAL**

Allergies  
Animal Abuse  
Cardiac Condition  
Physical/Sexual/Emotional Abuse  
Blood Pressure Control  
Dangerous to Self or Others  
Exacerbations of Medical Conditions (i.e. RA, MS)  
Fire Settings  
Hemophilia  
Medical Instability  
Migraines  
PVD  
Respiratory Compromise  
Recent Surgeries  
Substance Abuse  
Thought Control Disorders  
Weight Control Disorders

Thank you very much for your assistance. Should you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/phone indicated below.

Sincerely,  
Kathy Chitwood, RN,BC  
Program Director  
EQUI-VETS Service Program  
2626 Heritage Park Drive  
Virginia Beach VA 23456  
757-721-7350



## PARTICIPANT'S CONSENT FOR RELEASE OF INFORMATION

I hereby authorize: \_\_\_\_\_  
(person or facility)

to release information from the records of: \_\_\_\_\_ DOB: \_\_\_\_\_  
(participant's name)

The information is to be released to **EQUI-VETS Service Program**, a subsidiary of *EQUI-KIDS Therapeutic Riding Program*, located at 2626 Heritage Park Drive, Virginia Beach VA 23456 for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

- Medical history
- Physical therapy evaluation, assessment and program plan
- Speech therapy evaluation, assessment and program plan
- Mental health diagnosis and treatment plan
- Individual Habilitation Plan (I.H.P.)
- Classroom Individual Education Plan (I.E.P.)
- Psychosocial evaluation, assessment and program plan
- Cognitive-behavioral management plan
- Other: \_\_\_\_\_

This release is valid for one year and can be revoked, in writing, at my request.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relation to Participant: \_\_\_\_\_

Please send materials to: \_\_\_\_\_



## PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant Name \_\_\_\_\_ 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 Atlanto Axial Instability: \_\_\_\_\_

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

|                     |   |   | Comments |
|---------------------|---|---|----------|
| Auditory:           | Y | N | _____    |
| Visual:             | Y | N | _____    |
| Tactile Sensation:  | Y | N | _____    |
| Speech:             | Y | N | _____    |
| Cardiac:            | Y | N | _____    |
| Circulatory:        | Y | N | _____    |
| Integumentary/Skin: | Y | N | _____    |
| Immunity:           | Y | N | _____    |

Comments

|                          |       |   |       |
|--------------------------|-------|---|-------|
| Pulmonary:               | Y     | N | _____ |
| Neurologic:              | Y     | N | _____ |
| Muscular:                | Y     | N | _____ |
| Balance:                 | Y     | N | _____ |
| Orthopedic:              | Y     | N | _____ |
| Allergies:               | Y     | N | _____ |
| Learning Disability:     | Y     | N | _____ |
| Cognitive:               | Y     | N | _____ |
| Pain:                    | Y     | N | _____ |
| Emotional/Psychological: | Y     | N | _____ |
| Other:                   | _____ |   |       |

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that EQUI-VETS Service Program will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to EQUI-VETS for ongoing evaluation to determine eligibility for participation.

Name/Title: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_



## AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

### \*\*EQUI-VETS PARTICIPANT\*\*

In the event emergency medical aid treatment is required due to illness or injury during the course of participating with the **EQUI-VETS Service Program**, or while being on said premises of the organization, I hereby authorize **EQUI-VETS Service Program** and/or its representatives to:

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1. Obtain medical treatment and/or transportation if needed; and
2. Release client records upon request to the authorized agency or its representative involved in the medical emergency treatment

Participant Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/ZIP: \_\_\_\_\_

#### In the event that I am unconscious, please contact:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Physician's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Medical Facility: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Health Insurance Company: \_\_\_\_\_ Telephone: \_\_\_\_\_

In an effort to provide the best care possible, please indicate below:

I am allergic to the following medications: \_\_\_\_\_

I have the following ongoing medical conditions: (i.e.: Diabetes, Seizures, etc):  
\_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
EQUI-VETS Participant

### \*\*NON-CONSENT FOR MEDICAL TREATMENT\*\*

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I **DO NOT** give consent for emergency medical treatment for myself in the case of illness or injury during the course of participating in the lesson program or while on the premises of the **EQUI-VETS Service Program**.

In the event emergency treatment/aid is required, I wish the following procedure to take place:  
\_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
EQUI-VETS Participant

Printed Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_



## PARTICIPANT RELEASE AGREEMENT

I, \_\_\_\_\_ the undersigned adult participant, for and in consideration of the agreement of the **EQUI-VETS Service Program**, a subsidiary of *EQUI-KIDS Therapeutic Riding Program*, to provide equine-assisted activities and/or riding instruction for myself, do hereby forever release, acquit, discharge, and hold harmless **EQUI-VETS Service Program** and the **EQUI-KIDS Therapeutic Riding Program**, its officers, trustees, agents, employees, representatives, successors, and assigns, for all manner of claims, demands, and damages of every kind and nature whatsoever, which I may now or in the future have against the **EQUI-VETS Service Program** and the **EQUI-KIDS Therapeutic Riding Program**, its officers, trustees, agents, employees, representatives, successors, or assigns on account of any personal injuries, physical or mental condition, known or unknown, to myself, and the treatment thereof, as a result of, or in any way growing out of the acts of the **EQUI-VETS Service Program** and the **EQUI-KIDS Therapeutic Riding Program**, its officers, trustees, agents, employees, representatives, successors, or assigns, including but not limited to their negligence or gross negligence, in rendering the services above described or in any way incidental thereto. In accordance with Act 3.1-796.132 of the Code of Virginia, notice is hereby given on the intrinsic dangers of equine activities, including (i) the propensity of an equine to behave in dangerous ways which may result in injury to the participant; (ii) the inability to predict an equine's reaction to sound, movements, objects, persons, or animals; and (iii) hazards of surface or subsurface conditions.

Date: \_\_\_\_\_

\_\_\_\_\_  
EQUI-VETS Participant



## **PARTICIPATION POLICY AND PROCEDURES**

1. The purpose of therapeutic riding lessons shall be to foster positive self-awareness by all participants and allow for outdoor recreational opportunities for disabled service men and women.
2. Every attempt will be made, each session, to provide therapeutic riding lessons to new participants depending upon the availability of the class, disability of the participant and/or competence of the therapeutic riding instructor in that particular field of teaching.
3. It is our policy that once a session begins, classes are closed and shall remain so until the next series of lessons is open for registration. To incorporate new participants at various stages during these lessons not only detracts from the progress in that particular class, it does not allow for proper interaction between the new participant and the instructor. New participant orientation will be scheduled prior to every session to introduce new participants to the facility, instructors and horses; however, should there be a scheduling conflict the participant will be introduced to the program on the first lesson.
4. The EQUI-VETS Service Program is free to participants. Individuals interested in recreational/therapeutic riding must contact the Program Director to develop a lesson schedule suitable to meet the needs of the participant and the abilities of EQUI-VETS to provide the service.
5. Participants are encouraged to be ready for their lessons and arrive on time. Participants who are ten or more minutes late will not be permitted to take part in the lesson. If you are unable to attend a class, please contact our office or the instructor prior to your lesson day at the number below. Riders who accumulate three (3) unexcused absences in a lesson session will be removed from the program and fees are non-refundable.

### **EQUI-VETS/EQUI-KIDS Office: 757-721-7350**

6. Lessons will be held rain or shine. For severe weather conditions, such as hurricanes, severe lightening, snow, or tornados, participants will be contacted and make-up lessons will be scheduled. It is EQUI-VETS policy that make-up lessons may only be scheduled due to severe weather conditions, facility disruptions, or other unforeseen events. Make-up lessons will not be provided for missed lessons.
7. Family members under the age of 18 must be accompanied by an adult at all times.
8. Due to the nature of therapeutic riding, EQUI-VETS rider weight limit is 200 lbs., unless otherwise determined acceptable by the Program Director. The limitation has been established to ensure the soundness and well-being of all program horses and ponies. Special considerations will be reviewed on a case-by-case basis and applicants/participants are encouraged to discuss these considerations with the Program Director.

Date: \_\_\_\_\_

\_\_\_\_\_  
EQUI-VETS Participant



## PHOTOGRAPH AND MEDIA RELEASE

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to the **EQUI-VETS Service Program**, *an affiliate program offered by EQUI-KIDS THERAPEUTIC RIDING PROGRAM*, permission to take or have taken still and/or moving photographs and films, including, but not limited to, television pictures of myself \_\_\_\_\_, and consents and authorizes the **EQUI-VETS Service Program**, and its affiliates, advertising agencies, news media and any other persons interested in the **EQUI-VETS Service Program**, and its work, to use and reproduce the photographs, films, and pictures and to circulate and publicize the same by all means including without limiting the generality of the foregoing, newspapers, television media, brochures, pamphlets, instructional, clinical and/or research materials and books.

With respect to the foregoing matters, no inducements or promises have been made to me to secure my signature(s) to this release other than the intention of the **EQUI-VETS Service Program**, to use or cause to be used such photographs, films and pictures for the primary purpose of promoting and aiding the program and its mission.

Dated: \_\_\_\_\_

\_\_\_\_\_  
EQUI-VETS Participant

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### **\*\*NON-CONSENT FOR PHOTOGRAPH\*\***

For reasons that I am not obligated to disclose, **I DO NOT GIVE CONSENT** for photographs, either still or moving, or any television or news media, to be taken of myself by the **EQUI-VETS Service Program** or any persons working on behalf of said program. I understand that a **RED MARK** will be placed on the record kept in the administrative offices of the program, which will designate that photographs are not allowed of myself or said person.

Dated: \_\_\_\_\_

\_\_\_\_\_  
EQUI-VETS Participant