HORSE POWER HEALING CENTER, INC.

NEW STUDENT AVAILIBILTY

DATE:________________________

STUDENT NAME:____

PARENT/GUARDIAN NAME:____

PHONE:(__________)_________________ EMAIL:____

OTHER COMMENTS:____

Please indicate Days and Times Available for Lessons: Morning 8am-12pm Afternoon 12pm- 4pm Evening 4pm-6pm
Monday____________ Tuesday____________ Wednesday____________ Thursday___________ Friday ____________ Saturday____________ Sunday____________ First Choice:______________ Second Choice:_____________ Third Choice:_____________

** 2015 Lessons will be starting earlier plase let us know if your availabilty will change due to school conflicts.

____

____

PLEASE RETURN THIS FORM TO:
HORSE POWER HEALING CENTER, INC.
S.101 W.34628 HWY LO
EAGLE, WI 53119

www.horsepowerhealingcenter.com

Horse Power Healing Center, Inc.

Participant's Application and Health History

GENERAL INFORMATION

Participant: ____

DOB: ________________ Age: ___________ Height: ________ Weight: _________ Gender: M F

Address: ____

Phone: ____ Alternate phone: _______________________________

Email: ____

Parent/Legal Guardian: ____

Address (if different from above): ____

Phone: (if different from above): ____

How did you hear about our program? ____

Have you participated in an Equine-Assisted therapeutic program before? _____

If yes, when, where and for how long?____

Diagnosis: ____ Age of Onset: _______________

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)

____

____

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

____

____

____

GOALS (i.e. why are you applying for participation? What would you like to accomplish?)

____

____

Horse Power Healing Center, Inc. Participant Medical History

This form to be completed annually.

Participant Name:____ DOB:________________________

Diagnosis: ____ Date of Onset:_______________________

Current Height: ________________________ Current Weight:___________________

Seizures: Type:_______________________________________ Controlled: Yes/No Date of last seizure:____________________

Shunt present? Yes/ No Date of last revision:________________

Please indicate current or past special needs, concerns and/or surgeries in any of the following areas by circling yes or no. If yes, please comment.

Auditory: Y N ____

Visual: Y N ____

Tactile Sensation: Y N ____

Speech: Y N ____

Cardiac: Y N ____

Circulatory: Y N ____

Integumentary/Skin: Y N ____

Digestion: Y N ____

Elimination: Y N ____

Immunity: Y N ____

Pulmonary: Y N ____

Neurological: Y N ____

Muscular: Y N ____

Balance: Y N ____

Orthopedic: Y N ____

Allergies: Y N ____

Learning Disability: Y N ____

Cognitive: Y N ____

Emotional/Psychological Impairment: Y N ____

Behavioral: Y N ____

Pain: Y N ____

Other: Y N ____

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

Braces/ Assistive Devices:____

Special Precautions: ____

Additional Medical Information: ____

____

____

To the best of my knowledge the medical history is true and accurate:

Signature:____ Date:______________________

Signature of Participant, Parent or Legal Guardian

Horse Power Healing Center, Inc. & Jericho Creek Farms
Authorization for Emergency Medical Treatment Form/ Liability Release

Name: ____________________________________DOB: ______________ Phone: ___________________________________

Address: ____

Allergies to medications: __________________________________ Current medications: ______________________________

Allergies to any foods: ____

In the event of an emergency, contact:
Name: _____________________________________ Relation: _____________________ Phone: ________________________

Name: _____________________________________ Relation: _____________________ Phone:_________________________

Name: _____________________________________ Relation: _____________________ Phone:_________________________

Liability Release

Client/Rider/Participant Name: ____

would like to participate in the Horse Power Healing Center & Jericho Creek Farms activities programs. I acknowledge the risks potential risks of horseback riding. Under the Equine Activity Liability Act, each participant who engages in an equine activity expressly assumes the risks of engaging in and legal responsibility for injury, loss, or damage to person or property resulting from the risks of equine activities. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs, and assigned executors or administrators, waive and release forever all claims and damages against, Horse Power Healing Center & Jericho Creek Farms, equine activities, it's board of directors, instructors, therapists, aides, volunteers, boarding facilities, boarders, and/or property owners, and/or employees for any and all injuries which I/my son/my daughter/my ward may sustain while participating in the Horse Power Healing Center & Jericho Creek Farms activities programs.

Consent Signature: ____ Date: _______________________
Client/Rider/Participant, Parent or Legal Guardian

PHOTO RELEASE

I ☐ DO ☐ DO NOT

consent to and authorize the use and reproduction of any and all still and/or video photography and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the Horse Power Healing Center, Inc. & Jericho Creek Farms.

Signature: ____ Date: _____________________________
Client/Rider/Participant, Parent or Legal Guardian

Consent Plan

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while b the property of the agency, I authorize Horse Power Healing Center, Inc. & Jericho Creek Farms to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatme

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

Consent Signature: ____ Date: _________________
Client, Parent or Legal Guardian

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 service being on the property of Horse Power Healing Center, Inc. & Jericho Creek Farms.

Parent or guardian will remain on site at all times during equine assisted activities.
In the event that emergency treatment/aid is required, I wish the following procedure to take place:

____

Non-Consent Signature: ____ Date: ________________
Client, Parent or Legal Guardian

Horse Power Healing Center, Inc.
S.101 W.34628 Hwy LO
Eagle, WI 53119
Phone: 262-751-6525 or 262-594-3667
Fax: 262-594-5136
Email:horsepowerhealingcenter@yahoo.com
www.horsepowerhealingcenter.com

Date: ___________________________

Dear Healthcare Provider:

Your patient, ____, is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete the attached Medical History/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 Instabilities/ 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/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of Medical Conditions (ie. M.S., RA)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

Thank you so much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact our center.

Sincerely,

Horse Power Healing Center, Inc.

Horse Power Healing Center, Inc.

Medical History & Physician's Statement

(to be completed by physician)

Participant: ____DOB: __________ Height: ______ Weight: __________

Address: ____

Diagnosis: ____ Date of Onset: ________________________

Past/Prospective Surgeries: ____

Medications: ____

Seizure Type: ______________________________ Controlled: Y N Date of last seizure: _________________

Special Precautions/Needs: ____

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

Braces/Assistive Devices: ____

For those with Downs Syndrome: AtlantoDens Interval X-rays, date: ________________ Result + --

Neurological Symptoms of AtlantoAxial Instability: ____

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

	Y	**N**	**Comments**
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
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 Horse Power Healing Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Horse Power Healing Center for ongoing evaluation to determine eligibility for participation.

Name/Title: ____ MD DO

Signature: ____ Date: _________________

Address: ____

Phone: ____________________________________ License/UPIN Number: _______________________________