HORSE POWER HEALING CENTER, INC.

NEW STUDENT APPLICATION

DATE:_____

STUDENT NAME:_____

PARENT/GUARDIAN NAME:_____

PHONE:(_____)_____ EMAIL:_____

The best number to call if a lesson has to be canceled**:**_____

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_____**
First Choice:_____ Second Choice:_____ Third Choice:_____

**** Please let us know if your availability will change due to school conflicts.**

_____

_____

PLEASE RETURN THIS FORM TO:

HORSE POWER HEALING CENTER, INC.
S.101 W.34628 COUNTY ROAD 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?_____

Are you a Veteran or in the Military or anyone in your family_____

Diagnosis: _____ Age of Onset: _____

Anything else related to your diagnosis you think we should be aware of:

_____

_____

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)

_____

_____

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: _____

Current Medications:_____

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 & Wendy Konichek
Authorization for Emergency Medical Treatment Form/ Liability Release

Participant Name: _____ DOB: _____

Email: _____ Phone: _____

Allergies to any medications or foods: _____

In the event of an emergency, contact:

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 & Wendy Konichek, Norman and Linda Konichek, 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. **NOTICE: A person who is engaged for compensation in the rental of equines or equine equipment or tack or in the instruction of an person in the riding or driving of an equine or in being a passenger upon an equine is not liable for the injury or death of a person involved in equine activities resulting from the inherent risks of equine activities, as defined in Section 895.481 (1)(E) of the Wisconsin Statutes.**

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& Wendy Konichek, Norman and Linda Konichek,equine activities, its 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 and 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 & Wendy Konichek.

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

***** Please sign one of the Consent Plans below*****

Consent Plan

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

This authorization includes x-rays, 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.

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 on the property of Horse Power Healing Center, Inc. & Jericho Creek Farms & Wendy Konichek.
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. Medical History & Physician's Statement

(To be completed by physician)

Return this form to: Horse Power Healing Center S101 W34628 County Road LO Eagle, WI 53119
Phone: 262-594-3667 Fax: 262-594-5136 Email: info@horsepowerhealingcenter.com www.horsepowerhealingcenter.com

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: _____