HORSE POWER HEALING CENTER, INC.

RETURNING 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 this year so please let us know 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 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: _____

Physician's Name: _____ Preferred Medical Facility: _____

Allergies to medications: _____ Current medications: _____

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