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:______________________

Address: ____

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: _______________________________