



Welcome to Equine Dreams and thank you for your interest in therapeutic horseback riding!

- ❖ Please fill out the student packet and send all 11 pages to the address listed below.*
- ❖ If we have an opening, someone from Equine Dreams will contact you to schedule your orientation.*
- ❖ We look forward to meeting you!*

Send completed forms to:

*Equine Dreams, P.O. Box 372, Sandwich, IL 60548
Any Questions? E-mail us at: ride@equinedreams.org*

Equine Dreams Participant's Application and Health History

(to be completed by parent or legal guardian)

GENERAL INFORMATION

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____

Phone: _____ Email: _____ Alternate phone: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

Phone: _____

How did you hear about our program? _____

HEALTH HISTORY

Diagnosis: _____ Age of Onset: _____

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

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Vision			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

Equine Dreams Participant's Application and Health History (pg.2)

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?)

Signature: _____ Date: _____

PHOTO RELEASE

I DO

DO NOT

consent to and authorize the use and reproduction by Equine Dreams 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 program.

Signature: _____ Date: _____

Client, Parent or Legal Guardian

Equine Dreams Authorization for Emergency Medical Treatment Form/ Liability Release

Participant Staff Volunteer

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy#: _____

Allergies to medications: _____ Current medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Consent Plan

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize **Equine Dreams** 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.

Date: _____ Consent Signature: _____

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 services or while being on the property of Equine Dreams.

- 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:

Date: _____ Non-Consent Signature: _____

Client, Parent or Legal Guardian

Liability Release

_____ would like to participate in the Equine Dreams activities program. I acknowledge the risks and 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 Equine Dreams, 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 Equine Dreams activities program.

Date: _____ Consent Signature: _____

Client, Parent or Legal Guardian

(please send the next 2 forms to the participant's physician to be completed**)**



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 through email at ride@equinedreams.org.

Sincerely,

Equine Dreams Therapeutic Riding Center

Equine Dreams Participant's 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 Equine Dreams will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Equine Dreams for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____

Equine Dreams 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: **Equine Dreams**
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
- Occupational 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: _____

Equine Dreams Participant's Profile (to be completed by instructor)

Name: _____ Date: _____

Disability: _____

Ambulatory Status: _____

Adapted Equipment Required: _____

Mounting/Dismounting (method, number of volunteers) _____

Helpers required (indicate gait* assistance needed; update as needed):

Type of Assistance	Date	Gaits	Date	Gaits	Date	Gaits
Leader and 2 side walkers						
Leader and 1 side walkers						
Leader only						
Side walker						
Independent						

Riding Position (describe): _____

Riding skills (indicate gait*/task is completed; update as needed):

Task	Date	Gaits	Date	Gaits	Date	Gaits
Hold reins						
Hold handhold						
Able to control horse						
Able to circle at the...						
Rides w/out stirrups						
Able to maintain half seat						
Able to post at the...						
Knows diagonal or lead						
Able to steer over cavalletti						

Rider can walk _____ sitting trot _____ posting trot _____ canter _____

Horse recommendations _____

*Gaits Key: W – walk; ST – sitting trot; PT – posting trot; C - canter

PROGRESS NOTES (to be completed by instructor)

Date: _____
Instructor: _____

Name _____ **Start Date:** _____ **DOB:** _____

Volunteers: _____

Goals: _____

Horse/Mounts/Precautions: _____

Name _____ **Start Date:** _____ **DOB:** _____

Volunteers: _____

Goals: _____

Horse/Mounts/Precautions: _____

Name _____ **Start Date:** _____ **DOB:** _____

Volunteers: _____

Goals: _____

Horse/Mounts/Precautions: _____

Name _____ **Start Date:** _____ **DOB:** _____

Volunteers: _____

Goals: _____

Horse/Mounts/Precautions: _____

Name _____ **Start Date:** _____ **DOB:** _____

Volunteers: _____

Goals: _____

Horse/Mounts/Precautions: _____

Group Goals: _____

Week #1 Lesson Summary: _____

Week #2 Lesson Summary: _____

Week #3 Lesson Summary: _____

PROGRESS NOTES (pg. 2)

Week #3 Lesson Summary: _____

Week #4 Lesson Summary: _____

Week #5 Lesson Summary: _____

Week #6 Lesson Summary: _____

Week #7 Lesson Summary: _____

Week #8 Lesson Summary: _____

Week #9 Lesson Summary: _____

Week #10 Lesson Summary: _____

Week #11 Lesson Summary: _____

Week #12 Lesson Summary: _____

Semester Summary: _____

