PARTNERS
Therapeutic Horsemanship

New Student Welcome Packet

We are delighted you have chosen to join our program!

Attached are three forms we need you to complete and bring with you to your evaluation:

1. Release form
2. Application and Health History
3. Physician form

We provide lessons of 30 minutes. Lessons for students able to groom and tack horses are available for 50 minutes

Invoices are sent by email before each new session. Payment is due prior to the start of the session.

We have the following cancellation policies:

- COVID related - makeup week; credit to next session if more than 1
- Partners cancel - makeup week; credit to next session if more than 1
- Rider cancels for non-COVID related issue - no makeup/credit
- Riders with repeated no shows may lose priority for the following session.

We look forward to working with you and encourage you to share information to maximize progress.

PARTNERS
Therapeutic Horsemanship

Participant's Application & Health History

GENERAL INFORMATION

Participant: _____

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

Address: _____

Phone: _____ Alternative #: _____ Email _____

Referral Source: _____

Were you referred by the San Diego Regional Center (SDRC)? ☐ Yes ☐ No If Yes _____

Name of Service Coordinator: _____

Phone: _____ Email: _____

Parent/Legal Guardian: _____

Caregivers: _____

Address (if different from above): _____

Phone: _____

How did you hear about the program? _____

HEALTH HISTORY

Diagnosis: _____ Date of Onset: _____

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

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

MEDICATIONS (include prescription and over-the-counter, name, dose and frequency) _____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

PHYSICAL FUNCTION (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

PSYCHOSOCIAL FUNCTION (e.g., 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 Partners Therapeutic Horsemanship of any and all photographs 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

PARTNERS
Therapeutic Horsemanship

Participant's Application & Health History

GENERAL INFORMATION

Participant: _____

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

Address: _____

Phone: _____ Alternative #: _____ Email _____

Employer/School: _____

Employer/School Phone: _____

Parent/Legal Guardian: _____

Caregivers: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

Phone: _____

How did you hear about the program? _____

HEALTH HISTORY

Diagnosis: _____ Date of Onset: _____

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

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

MEDICATIONS (include prescription and over-the-counter, name, dose and frequency) _____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

PHYSICAL FUNCTION (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

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

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Signature _____ Date: _____

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Signature: _____ Date: _____

Client, Parent or Legal Guardian

Letter to Physician

PARTNERS
Therapeutic Horsemanship

Date: _____

Dear Health Care Provider:

Your patient,

_____
(participant's name)

is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and 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 Instability/Abnormalities

Neurologic Migraines
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders

Other
Age - under 4 years Weight Control Disorder
Indwelling Catheters/Medical Equipment
Medications - i.e. Photosensitivity
Poor Endurance
Skin Breakdown

Thank you very 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 the center at the address/phone indicated above.
Sincerely, Partners Therapeutic Horsemanship

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International
MEMBER

PARTNERS
Therapeutic Horsemanship

Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs: _____

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

Braces/Assistive Devices: _____

For those with Down syndrome: Neurologic Symptoms of Atlantoaxial Instability: ❑ Present ❑ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	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			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that Partners Therapeutic Horsemanship will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to PTH for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other

Signature: _____ Date: _____

Address: _____

Phone: (____) _____ License/UPIN Number: _____

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Partners Therapeutic Horsemanship, Inc

AGREEMENT FORM FOR FULL ASSUMPTION OF RISK AND RELEASE OF ALL LIABILITY

Volunteer/Student Name _____ Age _____

Phone numbers Home _____

Cell _____ Work _____

Email _____

Address: _____

City & Zip _____

I, the undersigned, am of legal adult age and of sound mind do for myself, or on behalf of my child or legal ward, or other minor listed below, for whom I hereby attest to accepting full responsibility for (hereinafter all inclusively "the rider"), hereby voluntarily request to participate in the horseback riding activities directed by Partners Therapeutic Horsemanship.

I, and/or the rider will ride and work with either a horse provided by Partners, my own horse, or a horse provided by a third party. I understand that I and/or the rider is responsible for all bodily injury and or property damage which I, and or the rider, and or the rider's horse should cause or receive either on the premises of Richard Smith, Mountain View Ranch or any other property, including any trails, while accompanying other horses or riding alone or receiving instruction. Furthermore, I accept all responsibility and liability for any incident involving the rider and or the rider's horse with any other rider, horse, individual or property.

I understand that horseback riding is a dangerous activity and that there are dangers from even being near a horse and that any horse, even the gentlest, can be provoked or frightened and as a result act or react in a dangerous or unpredictable manner. We agree not to touch, pet or feed any horses or enter the horse's pens without the horse owners' permission or to provoke or otherwise influence our horse or the horse of another rider at any time as this can be very dangerous.

I understand that horses are animals and as such are unpredictable by nature; that when frightened, angry, under stress, or for no reason at all, a horse's natural instincts are to move, shake, bolt, jump forward or sideways, to run away from danger, to kick, to buck, to rear up in front, or to bite. Any horse may bite or kick me or anther rider or horse. I understand that horses are extremely heavy and powerful and that if I fall to the ground the fall distance will be generally from 4 to 6 feet or if a horse lays down on me that the weight may be between 500 to 2,000 pounds. I understand that any or all the horse activities directed by Partners Therapeutic Horsemanship, Inc., or their representatives, may cause myself and or the rider serious permanent injury or death and I, and or the rider, agree to participate in this activity willingly and voluntarily.

I hereby agree not to bring any suit against Partners Therapeutic Horsemanship, Inc., or their representatives, their successors, assigns, agents, affiliates, owners, employees, officers, members or Board of Directors, advertisers, sponsors or supporters and volunteers for any reason at any time now or in the future for any injury, damage, or incident which may occur as a result of my participation in any activity offered and provided by or affiliated with Partners Therapeutic Horsemanship, Inc., or their representative. I and the rider hereby for ourselves, heirs, administrators, assigns and representatives completely release, indemnify, hold harmless and discharge the owners, operator, sponsors, agents, associates and employees of Partners Therapeutic Horsemanship, Inc., or their representatives, and their respective agents, representatives, associates and all other participants of and from Partners Therapeutic Horsemanship, Inc. equestrian activities. I furthermore agree to reimburse Partners Therapeutic Horsemanship, Inc. upon demand for any and all expenses incurred as a result of any action, legal or otherwise, that I, my heirs, administrators, assigns, representatives or agents or those of the rider may initiate against Partners Therapeutic Horsemanship, Inc., and/or their agents, representatives, associates or other participants now or in the future.

I understand Richard Smith and Mountain View Ranch are a completely separate entity from Partners Therapeutic Horsemanship, Inc., and hereby agree not to bring any suit against and Richard Smith and Mountain View Ranch, his clients or client's horses, his successors, assigns, agents, affiliates, employees, officers, members or Board of Directors, advertisers, sponsors or supporters and volunteers for any reason at any time now or in the future for any injury, damage, or incident which may occur as a result of my participation in any activity offered and provided by or affiliated with Partners Therapeutic Horsemanship, Inc. I and the rider hereby for ourselves, heirs, administrators, assigns and representatives.

Print Responsible Adult's (Volunteer or Parent, Guardian Care Giver) Names (s):

_____

Responsible Adult's Signature:

_____ Date _____