

Participant's Application & Health History



GENERAL INFORMATION

Participant: _____

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

Address: _____

Phone: _____ Email: _____ Alternative #: _____

Employer/School: _____

Address: _____

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.)

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 Sarasota Manatee Association for Riding Therapy (SMART) of any and all photographs and any other audio/visual materials taken of me for promotion material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Client, Parent or Legal Guardian



Date: _____

Dear Health Care Provider:

Your patient _____ 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

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/
Tethered Cord/Hydromyelia

Other

Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – e.g., 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
Fire Setting
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted services, please feel free to contact the center at the address/phone indicated below.

Sincerely,
Rebecca Blitz
Sarasota Manatee Association for Riding Therapy
4640 CR 675
Bradenton, FL 34211
(941) 322-2000

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			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted services. I understand that Sarasota Manatee Association for Riding Therapy (SMART) will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to SMART for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____



Sarasota-Manatee Association for Riding Therapy

4640 CR 675, Bradenton, FL 34211

(941) 322-2000

Authorization for Emergency Medical Treatment

CONSENT PLAN

In the event emergency medical aid/treatment is required due to illness or injury while participating in the Sarasota Manatee Association for Riding Therapy (SMART) program, I authorize SMART to secure and retain medical treatment and transportation if needed. This authorization includes but is not limited to x-ray, surgery, hospitalization, medication and any treatment deemed "life-saving" by the physician. In addition, I authorized SMART to release my records to any individual involved in medical treatment and/or transportation I might need. This provision will be invoked only if the emergency contact person(s) listed below is/are unable to be reached.

Date _____ Participant's name (print) _____ DOB _____

Home phone # _____ Street Address _____

City _____ State _____ Zip _____

In case of emergency, contact:

Name _____ Relationship: _____ Phone Number(s) _____

Physician's name _____ Phone Number _____

Preferred medical facility _____

Allergies to Medications _____

Current Medications: _____

Health insurance company _____ Policy # _____

Consent Authorized Signature _____ **Date:** _____
(Participant OR Parent / Legal Guardian if under 18)

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment in the case of illness or injury while participating in the SMART program. In the event emergency treatment aid is required, I wish the following procedures to take place: (list procedures)

Date _____ Participant's name (print) _____

Non-Consent Authorized Signature _____
(Participant OR Parent / Legal Guardian if under 18)



SMART RULES

These rules are designed to ensure the safety of all humans and equines at SMART.

1. No abusive, threatening, or violent behavior will be tolerated on the premises.
2. Illegal drug and alcohol use are prohibited.
3. NO smoking in or around the stable grounds. Smoking is permitted only in the privacy of your vehicle in the parking lot. *Please do not leave your cigarette butts in the grass or on the premises!*
4. All visits to the SMART facility must be supervised by a staff member.
5. Please park in the grassy lot by the arena NOT the driveways near the pavilion.
6. During lesson times, all participants and other children must be supervised by their Parents or Care Providers until they are attended to by SMART Staff. No running or screaming is allowed in the stables or around the horses.
7. Participants are not allowed to play on the ramp, mounting blocks, gates and fences.
8. Parents, care providers, siblings and friends must remain in the designated waiting areas (pavilion and grassy area surrounding it or parking lot) during their participant's lesson unless accompanied or approved by staff.
9. The mounting ramp and mounting blocks are only to be used for mounting and dismounting participants. Only instructors and trained staff will assist with the mounting and dismounting of participants.
10. Please do not handle, feed or pet horses in their stalls or in their paddocks unless supervised or approved by a staff member.
11. No one may enter a stall, paddock or arena containing horses unless accompanied or approved by a staff member.
12. No one may ride a horse unless supervised by a SMART Instructor. All program participants must have an annually completed Application and Release packet on file.
13. All riders must wear an ASTM-approved helmet while mounted on horses and use safety stirrups. We recommend that all riders wear hard-soled shoes with heels and long pants.
14. All accidents, injuries or hazardous conditions must be reported to a staff member immediately. In case of emergency, please follow the directions given by the Instructor(s) and/or Staff in charge.
15. **No dogs or pets belonging to volunteers, participants or visitors are allowed on the property!**
16. **Please obey all signage.**

WARNING: Under Florida Law, an equine activity sponsor or equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.

I have read and understand all of the rules above and agree to abide by them.

Signature _____ **Date** _____



Sarasota Manatee Association for Riding Therapy

4640 County Road 675

Bradenton, FL 34211

(941) 322-2000

RELEASE AND ASSUMPTION OF RISK AGREEMENT

I agree to the following Release and Assumption of Risk Agreement with SARASOTA MANATEE ASSOCIATION FOR RIDING THERAPY, INC., a Florida nonprofit corporation (hereafter referred to as "SMART") as a condition for allowing me or my child /legal ward identified below to enter SMART's premises, surrounding land, and other program locations, be near horses, participate in equine-assisted activities, work near horses, handle horses, use equipment, work with staff and volunteers, and/or receive instruction or guidance while riding, grooming, or handling horses. This is not meant to be a complete list of all activities and will be referred to in this document as "The Activities".

IT IS HEREBY AGREED AS FOLLOWS:

1. I have voluntarily requested, for myself or for my child/legal ward identified below, to engage in any or all of The Activities, now and/or in the future.
2. Risks. I understand that anyone engaging in The Activities can suffer bodily injuries, property damage and other injuries including death. Participation in The Activities involves certain inherent risks and, regardless of the care that is taken, it is impossible to ensure the safety of the participant. I understand the risks/dangers inherent in The Activities, and I agree to assume them. I am not relying on SMART to list all possible risks for me or my child/legal ward.
3. Waiver and Liability Release: As consideration for SMART allowing me or my child/legal ward to engage in The Activities at any time and at any location, I do hereby voluntarily assume all risks of loss, damage or personal bodily injury including death that may be sustained which may hereinafter occur on account of, or in any way arising from, entry upon the premises or participation in The Activities on or off the premises. I, for my heirs, administrators, personal representatives, or assigns, release and discharge SMART, and all SMART employees, assistants, directors, volunteers, instructors, officers, and owners of horses from any and all claims, demands, damages, actions, omissions, suits, or causes of action (present or future).
4. Indemnification: I also understand and agree to indemnify and hold harmless SMART and persons or entities working on behalf of or affiliated with SMART against any and all further claims or damages, cost or expenses incurred by SMART and their employees as a result of an accident, injury or property loss which may occur while I, or my child/legal ward are on or off the premises or engaged in The Activities connected with SMART which may result from negligence of the undersigned or the negligence of SMART, employees, volunteers, instructors, agents, third parties or any combination thereof of SMART. The indemnification shall include reimbursement of SMART'S attorney fees.
5. ASTM/SEI Headgear is required to be worn by all participants and can be purchased through SMART. I understand that neither SMART nor its assistants or agents can guarantee the suitability of any helmet provided.
6. Health and Disabilities: I understand that SMART always recommends that I seek the advice of a physician if I or my child/legal ward is injured, and many of The Activities pose special physical risks to the participant.
7. Should I breach this Release (or any part of it) I agree to pay the attorney's fees and court costs related to such breach incurred by SMART and/or persons directly affiliated with SMART. It is also mutually agreed that any disputes arising under this Release, or any activities that are undertaken pursuant to this document, shall be litigated in a court of proper jurisdiction located in or nearest to Manatee County, Florida.

I understand that when signed, this Agreement is intended to be legal, valid and binding at all times, now and in the future, when SMART permits me or my child/legal ward to engage in any or all of The Activities either on the SMART premises or other designated program locations.

WARNING: Under Florida Law, an equine activity sponsor or equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.

NAME OF PARTICIPANT _____

SIGNATURE OF PARTICIPANT if 18 or older _____ DATE _____

Address of Participant: _____

Phone: (Home) _____ (Cell/other) _____ Email: _____

I hereby certify that I am authorized to sign this Release and Assumption of Risk Agreement on behalf of the Participant.

SIGNATURE OF PARENT OR LEGAL GUARDIAN _____ DATE _____

Print name of Parent or Legal Guardian: _____

Address _____

Phone: (Home) _____ (Cell/other) _____ Email: _____

Acknowledgement and Consent to Release Records to Manatee County Government

***This form should be completed only for Participants residing in Manatee
County
under the age of 18 years old.***

Name of Participant: _____

I hereby acknowledge and consent to release to Manatee County Government's Representative the Agency records of my child or legal ward from Sarasota Manatee Association for Riding Therapy, Inc. (SMART). These records relating to the program or delivery of services may be required by the County for purposes of monitoring and evaluating services.

I also understand that to the extent records are provided to the County, same shall become public records under Chapter 119, Florida Statutes and may be subject to any applicable state or federal exemptions and be inspected or copied by third persons.

Signature of Parent or Legal Guardian

Date



Sarasota-Manatee Association for Riding Therapy

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Participant Information

Participant's Name: _____

Describe briefly what you think this participant's strengths and talents are:

Describe briefly what you think this participant's weaknesses are:

Check those that accurately describe the participant:

Best Teaching Strategy

_____ Auditory

_____ Visual

_____ Kinesthetic

_____ Visual-Kinesthetic

_____ Auditory-Visual

_____ Auditory-Visual-Kinesthetic

Laterality

_____ Is able to differentiate between his/her left hand

_____ Is able to differentiate between his/her right hand

_____ Appears to use both right and left sides equally

Motor Coordination and Body Image

_____ Has tightly muscled body

_____ Has low muscle tone

_____ Has average muscle tone

_____ Is coordinated and plays in many sports well

_____ Has difficulty playing some sports

_____ Does not like to be touched

_____ Does not seem to be aware of his/her body in space

_____ Pays attention to body cues, knows when hungry, tired/takes care of bodily needs

_____ Is skin sensitive and complains at times that clothing is too rough or hurts

_____ Compulsively overeats

_____ Stumbles and trips, runs into things or knocks things over often

Social and Emotional Adjustment

_____ Appears to be appropriately independent, self-reliant and mature for age

_____ Appears to have a positive self-image

_____ Can be very hard on him or herself

_____ Whines, complains and generally manipulates

_____ Is able to get along with others

_____ Is direct and can ask for what he/she needs and wants

_____ Performance is uneven and marked good and bad days

_____ Tires easily

_____ Is argumentative and oppositional at times

_____ Wants to please

_____ Has anxiety exhibited by stomach aches, headaches or other symptoms

_____ Shows anxiety by chewing on clothing, toys or own body

Observed Behaviors

_____ Distracted by internal stimuli

_____ Distracted by external stimuli

_____ Needs constant reminders to stay on task

_____ Needs occasional reminders to stay on task

_____ Is easily bored

_____ Needs several minutes to process information before acting

_____ Needs repetition in order to internalize feedback or instruction

_____ Gives up when frustrated

_____ Is determined and keeps trying

Do you have any other comments that would help us better understand the participant?

Signature: _____ Date: _____

Relationship to participant: _____