Saddle Up of the Antelope Valley

8628 West Avenue E

Lancaster, CA 93536

PATH INTERNATIONAL

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) _____

_____

_____

_____

_____

PSYCHO/SOCIAL 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 _____
(center)

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 benefi t of the program.

Signature: _____ Date: _____

Client, Parent or Legal Guardian

Signed in the presence of center staff

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PATH INTERNATIONAL

Authorization for Emergency Medical Treatment Form

o Participant o Staff o 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 _____ to:

(Center's Name)

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-ray, 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

Signed in presence of center staff

Saddle Up of the Antelope Valley

Horseback Riding Agreement and Release of Liability Form

Rider Name:_____Date of Birth_____

Address_____City_____State_____

Zip_____Telephone_____Alternate phone_____

Liability Release: I understand that this is a high-risk sport and I am participating at my own risk. I hereby assume this risk and further do hereby release and hold harmless the owners of the property, and its agents, employees, volunteers, and the host of this "equestrian activity" from all liability for negligence resulting in accidents, damage, injury or illness to myself and to my property, including the horse or horses which I will ride at this facility.

Release, Assumption of Risk, Waiver and Indemnification

********This document waives important legal rights. Read it carefully before signing.********

I AGREE in consideration for my participation in this "equestrian activity" at Saddle Up Therapeutic Riding Stables to the following:

I AGREE that I choose to participate voluntarily in the "equestrian activity" with a horse, as a rider, lessee owner, agent, coach, trainer, or as parent or guardian of a junior rider, I am fully aware and acknowledge that horse sports involve inherent dangerous risks of accident, loss, and serious bodily injury including but not limited to broken bones, head injuries, trauma, pain, suffering, or death ("Harm").

I AGREE to release the "equestrian activity", the property owners, and its agents, employees, volunteers, and the host of this "equestrian activity" from all claims for money damages or otherwise for any Harm to me or a horse and for any Harm caused by me or a horse to others, even if the Harm resulted, directly or indirectly, from the negligence of the "equestrian activity."

I AGREE to expressly assume all risks of Harm to me or a horse, including Harm resulting from the negligence of the "equestrian activity", the property owners, and its agents, employees, volunteers, and the host of this "equestrian activity."

I AGREE to indemnify (that is, to pay any losses, damages, or costs incurred by) the "equestrian activity", the property owners, and its agents, employees, volunteers, the host of this "equestrian activity", and to hold them harmless with respect to claims for Harm to me or a horse, and for claims made by others for any Harm caused by me or a horse at this facility.

I am entitled to wear protective equipment without penalty, and I acknowledge that the "equestrian activity", the property owners, and its agents, employees, volunteers, and the host

of the "equestrian activity" requires me to do so while WARNING that no protective equipment can guard against all injuries.

If I am a parent or guardian of a minor rider, I consent to the child's participation and AGREE to all of the above provisions and AGREE to assume all of the obligations of this Release on the child's behalf.

I AGREE that the "equestrian activity" as used above includes all the property owners, its agents, employees, volunteers, and the host of this "equestrian activity."

BY SIGNING BELOW, I UNDERSTAND AND AGREE to be bound by all applicable terms and provisions of this riding agreement.

Rider's Signature_____Date_____

Parent/Guardian Signature_____Date_____

Parent/Guardian Signature required if rider is under age 18

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CONFIDENTIALITY POLICY

1. Saddle Up Therapeutic Riding Stables (Saddle Up) and its staff members understand the importance of preserving the right of confidentiality for all individuals in its program.

2. Staff members include, but are not limited to, full-time and part-time employees, board members, independent contractors, temporary employees, and volunteers.

3. Saddle Up and its staff members shall keep confidential and refuse to disclose any and all medical, social, referral, personal and financial information, regarding a rider and his/her family, to any person or agency which is not related to Saddle Up or its programs.

4. The disclosure of any medical, social, referral, personal or financial information to outside individuals or agencies is permitted only when the rider, his/her parents, or his/her guardian provide specific written consent.

5. Any failure to comply with this Confidentiality Policy will result in personal and professional penalties, including but not limited to, reprimand, loss of certain job responsibilities and termination.

6. I understand and will observe the Confidentiality Policy of Saddle Up Therapeutic Riding Stables.

_____ _____

Signature Date

_____ _____

Witness Witness Title

Saddle Up of the Av
8628 W. Ave E
Lancaster, CA 93536

PATH INTERNATIONAL

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			
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 and/or therapies. I understand that the PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____
Signature: _____ Date: _____
Address: _____
Phone: (___) _____ License/UPIN Number: _____