Therapeutic Participant Application

Participant: ____DOB: _____________

Age: ___________ Gender: M F Height: _____________ Weight: _______________

Diagnosis: ____ Date of Onset: _____________

Address: ____

City: ____ Zip:_____________________

Phone: ______________________ Email: ____

School/Employer: ____

Name Parent/Legal Guardian: ____

Caregivers: ____

Does participant have past experience in an equine-assisted therapy program? Yes No

If so, which program? ____

How did you hear about Hope Retreat Ranch? _______________________________________

Referral Source? From:____

Are you enrolled in Self Directed Services? Yes No

Goals: (What would participant like to accomplish in the program?)

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

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

Medications: (That we may need to be aware of)

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Physical Function: (Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

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Psycho-social Function: (Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

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Signature: ____ Date of Application: _______________

Participant Liability Release

Participant, ______________________________, is participating in the Hope Retreat Ranch Therapeutic Riding Program. I acknowledge the risks and potential for risks of working with and of being around horses/horseback riding. However, I believe the possible benefits to myself/my child/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Hope Retreat Ranch Therapeutic Riding Program, the Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses that I/my child/my ward may sustain while participating with the Hope Retreat Ranch Therapeutic Riding Program.

Signature: ____ Date: __________________

Confidentiality Agreement

I understand that all information, written and verbal, about participants at Hope Retreat Ranch Therapeutic Riding Program is confidential and will not be shared with anyone outside of our program without the express written consent of the participant and their parent/guardian in the case of a minor.

Signature: ____ Date: __________________

Photo Release

I DO / DO NOT consent to and authorize the use and reproduction by Hope Retreat Ranch Therapeutic Riding Program of any and all photographs and any other audio/visual materials taken of me, my minor child or my ward for promotional purposes, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: ____ Date: __________________

Authorization for Emergency Medical Treatment

Name: ___________________________________ DOB: ______________Cell: ____________________

Healthcare Provider's Name: ____________________________________ Phone: _________________

Preferred Medical Facility: ____

Health Insurance Company: ______________________________ Policy #: _______________________

Allergies to Medications: ____

Current Medications: ____

In the event of an emergency, contact:

Name: ________________________________ Relation: _____________ Cell: ___________________

Name: ________________________________ Relation: _____________ Cell: ___________________

In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while on the property of the organization, I authorize Hope Retreat Ranch Therapeutic Riding Program to:

1. Secure and retain emergency medical treatment and transportation as needed.
2. Release client records upon request to the authorized personnel or agency involved in rendering emergency medical treatment.

Consent Plan

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.

Consent Signature: ____ Date: ___________________

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 on the property of the organization. In the event emergency treatment/aid is required, I wish the following procedures to be taken:

____

Non-Consent Signature: ______________________________________ Date: ____________________