Therapeutic Riding Center
14764 South HWY-169
Oologah, OK 74053
(918) 371-1750
FAX: (918) 371-1930
Administration@bitbybitok.org

LIABILITY RELEASE

____
(participant's name)

would like to participate in the Bit-by-Bit therapeutic horseback riding program. I acknowledge the risks and potential risks of horseback riding. 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 assigns, executors or administrators, waive and release forever all claims for damages against Bit-by-Bit therapeutic horseback riding program, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/ my son/ my daughter/ my ward may sustain while participating in Bit-by-Bit's therapeutic horseback riding program.

Under Oklahoma 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.

Signature:_______________________________________ Date: ________________
(participant, parent, or guardian)

Print Name: ____

PHOTO RELEASE

I ❑ DO
I ❑ DO NOT

consent to and authorize the use and reproduction by Bit by Bit Therapeutic Riding 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 benefit of the program.

Date:_______________________________________

Signature: __________________________________
Client, Parent or Legal Guardian

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

❑ 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:__________________________Phone: (____)______________Relation to Participant: ______________

Name: __________________________ Phone: (____)______________ Relation to Participant: _____________

Name: __________________________ Phone: (____)______________ Relation to Participant: _____________

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 Bit by Bit Therapeutic Riding Center 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-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

NON-CONSENT PLAN

I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services, or while being on the property of the agency.

❑ Parent or legal guardian will remain on site at all times during equine assisted activities

Date:_______________Non-Consent Signature:____

Client, Parent or Legal Guardian

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: ____________________

<u>Please note that long pants and closed toe shoes with a heel are a safety requirement for riding. If the participant needs an accommodation please speak with your instructor, or the center director.</u>

Participant's Consent for Release of Information

I hereby authorize: ____

to release information from the records of: ______________________________ DOB: _________________
(participant's name)

The information is to be released to: Bit by Bit Therapeutic Riding Center ______________________

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
- ❑ Speech therapy evaluation, assessment and program plan
- ❑ Mental health diagnosis and treatment plan
- ❑ Individual Habilitation Plan (IHP)
- ❑ Classroom Individual Education Plan (IEP)
- ❑ 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: Bit by Bit Therapeutic Riding Center
14674 South Highway 169
Oologah, OK 74053
Phone: (918)371-1750
Fax: (918)371-1930

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

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 (e.g., RA, MS)

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,

Bit by Bit Therapeutic Riding Center 14674 S. Highway 169 Oologah, OK 74053 (918)371-1750 Administrationt@BitbyBitok.org

Date:________________________________

Dear Health Care Provider:

Your patient ____

(participant's name)

has been participating in supervised equine activities at Bit by Bit Therapeutic Riding Center

and is due for an update of their medical status. Please review the previous medical history and provide an update of the information in the space below. Address occurrences over the past year including surgeries, illnesses, hospitalizations, changes in medications, treatment, weight or behavior. Please indicate current height/weight. For your reference, potential precautions/contraindications are listed on the reverse. If this person has Down syndrome or any other condition that predisposes them to Atlantoaxial Instability, please include results of their neurologic exam.

Diagnosis: ____

Height:______________Weight: ________________

Update Status: ____

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____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted services. 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

Signature:____Date:______________________

Address:____

Phone: (_____)_________________________________License/UPIN Number: ______________________________

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 services. 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

Signature:______________________________________Date:________________

Address:____

Phone: (_____)________________________License/UPIN Number: ____________________