Equestrian Center
16544 A. South HWY-169
Oologah, OK 74053
(918) 371-1750
FAX: (918) 371-1930

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, Rogers State University, it's 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** (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 center.

Signature: _____ Date: _____
(participant, parent, or 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 _____ 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

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
❑ In the event emergency aid/treatment is required, I wish the following procedure to take place:

_____
_____
_____

Date: _____ Non-Consent Signature: _____

Client, Parent or Legal Guardian
Signed in presence of center staff

PARTICIPANT'S APPLICATION AND HEALTH HISTORY

GENERAL INFORMATION

Participant: _____

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

Address: _____

Phone: (___) _____ Alternative Phone #: (___) _____ E-mail: _____

School District: _____

School Address: _____ School Phone #: (___) _____

Parent/Legal Guardian/Caregivers: _____

Address *(if different from above)*: _____ Phone: (___) _____

How did you hear about the program? _____

IMMEDIATE CONTACTS *(for any reason)*

Name: _____ Phone: (___) _____ Relation to Participant: _____

Name: _____ Phone: (___) _____ Relation to Participant: _____

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, over-the-counter: name, dose and frequency)*

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

PHYSICAL FUNCTION *(i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)*

PSYCHO/SOCIAL FUNCTION *(i.e. 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: _____

PARTICIPANT'S CONSENT FOR RELEASE OF INFORMATION

I hereby authorize: _____
(person or facility)

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

The information is to be released to: _____
(center or therapist's name)

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
- ❑ Occupational Therapy evaluation, assessment and program plan
- ❑ Speech Therapy evaluation, assessment and program plan
- ❑ Mental Health diagnosis and treatment plan
- ❑ Individual Habilitation Plan (I.H.P.)
- ❑ Classroom Individual Education Plan (I.E.P.)
- ❑ 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: _____

_____

_____

_____

Date: _____

Dear Health Care Provider:

Your patient, _____
(participant's name)

has been participating in equine activities program at _____
(center)

and is due for an update of their medical status. Please review their previous medical history and provide an update of the information in the space below. Address occurrences over the past year including surgeries, illnesses, and hospitalizations, changes in medications, treatment, weight, or behavior. Please indicate current height/weight. For your reference, potential precautions/contraindications are listed on the next page.

Diagnosis: _____

Height: _____ Weight: _____

Update Status: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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 NARHA center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the NARHA center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

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

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
Coxa Arthrosis
Cranial Deficits
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 - i.e. 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 (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for you 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,

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 Onset: _____
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: AtlantoDens Interval X-rays Date: _____ Result: -- +
Neurologic Symptoms of AtlantoAxial Instability: _____
Please indicate current or past special needs in the following systems/areas, including surgeries:

	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 activities. I understand that the NARHA center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the NARHA center for ongoing evaluation to determine eligibility for participation.

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