Bit by Bit Therapeutic Riding Center
14674 US-169
Oologah, OK 74053
FAX: (918) 371-1930
PHONE: (918) 371-1750
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, pursuant to the Oklahoma Equine Activities Liability Act.

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.

Signature: _____Date:_____
Client, Parent or Legal Guardian

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

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 must 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 from patient, parent, and/or caregiver

Participant: _____

DOB: _____Age: _____Height: _____Weight: _____Gender (circle): 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? _____

For grant and recording purposes:

Please share your race: (Caucasian, Latino, Asian, Other) _____

Are you a registered member of an American Indian or Alaskan Native tribe or nation?

Y/N and which Tribe_____

HEALTH HISTORY

(from Participant or Parent/Gaurdian)

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) _____

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: _____

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.

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 EquipmentMedications - 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 inequine-assisted services, please feel free to contact the center at the address/phone indicated below.

Sincerely,

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

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: _____

Braces/Assistive Mobilty 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 conditionsmay 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 againstthe existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoingevaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Signature: ____

_____ Date: _____ Address: ____

_____ Phone: (_____)

_____ License/UPIN Number: _____