

*Dreams Come  
True  
Therapeutic  
Riding, Inc.*

Dreams Come True  
Therapeutic Riding  
639 County Road 513 office phone: 908-735-5912  
Pittstown, NJ 08867 fax: 908-735-2137

## Participant's Application and Health History

Participant: \_\_\_\_\_ Date \_\_\_\_\_

Birth date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ M F

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternative # \_\_\_\_\_

Participant's Diagnosis: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Parent/Legal Guardian Name and Address: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

How did you learn about the program? \_\_\_\_\_

### HEALTH HISTORY

| PROBLEM AREAS                      | Y | N | COMMENTS |
|------------------------------------|---|---|----------|
| VISION                             |   |   |          |
| HEARING                            |   |   |          |
| SENSATION                          |   |   |          |
| COMMUNICATION                      |   |   |          |
| HEART                              |   |   |          |
| BREATHING                          |   |   |          |
| DIGESTION                          |   |   |          |
| ELIMINATION                        |   |   |          |
| CIRCULATION                        |   |   |          |
| EMOTIONAL                          |   |   |          |
| BEHAVIORAL                         |   |   |          |
| PAIN                               |   |   |          |
| BONE/JOINT                         |   |   |          |
| MUSCULAR                           |   |   |          |
| THINKING/COGNITION                 |   |   |          |
| NEUROLOGICAL                       |   |   |          |
| ALLERGIES                          |   |   |          |
| DOWN SYNDROME                      |   |   |          |
| LEARNING DISABILITIES<br>(Specify) |   |   |          |
| OTHER                              |   |   |          |

What Medications are currently being taken including over-the-counter medications?

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

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

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SOCIAL (i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns)

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GOALS (i.e. Why are you applying for participation? What would you like to accomplish?)

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### Releases

**Photo Release:**

- I  DO
- DO NOT

Consent to an authorize the use and reproduction by Dreams Come True Therapeutic Riding (DCTTR) of any and all photographs and any other audio/visual materials taken of me/my child for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

**Horseback Riding Release of Liability and Indemnity Agreement**

I, \_\_\_\_\_, hereby acknowledge that I and/or my legal guardian on my behalf have voluntarily registered to participate in an activity of horseback riding with Dreams Come True Therapeutic Riding (DCTTR) Program.

I fully understand that the activity of horseback riding, or even being near a horse, involves numerous dangers and risks of injury to me. I acknowledge that the assumption of all the risks involved is my responsibility and I completely release Dreams Come True Therapeutic Riding Program and its agents from all liability for any and all injuries caused by my participation in the general activity of horseback riding. 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 DCTTR, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my child may sustain while participating in DCTTR activities.

I fully understand that an animal (horse) irrespective of its training and usual past behavior and characteristics, may act or react unpredictably based on instinct or fright, and that even the most gentle horse, when provoked or frightened, may kick, bite, rear, buck, run away or otherwise act in an unpredictable and dangerous manner. In addition, weather such as thunder, hail, lightening, or snow sliding off the roof, may cause a horse to act in an unpredictable and dangerous manner. I also fully understand that I may, at any time, lose control of and/or fall off my horse. Having understood these dangers, I fully assume all of the risks involved and completely release Dreams Come True Therapeutic Riding Program and its agents from liability for any and all injuries to me from the general activity of horseback riding.

I agree not to sue, claim against, attach the property of or prosecute HCEF or HC Therapeutic Riding, its officers, board members, affiliated organizations, agents and/or its employees for riding and its related activities, whether or not such injury or death was caused by their negligence or from any other cause.

I agree to defend, indemnify and hold harmless Dreams Come True Therapeutic Riding and all of its officers, board members, affiliated organizations, agents and employees for any injury or death caused by or resulting from my participation in the activity of horseback riding and its related activities, whether or not such injury or death was caused by their negligence or from any other cause.

This agreement shall be legally binding upon me, my family, my heirs, my estate, assigns, legal guardians, and my personal representatives.

I have carefully read this agreement and fully understand its contents. I am aware that I am releasing certain legal rights that I otherwise may have and I enter into this release of liability and indemnity agreement on behalf of myself of my own free will.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent or legal guardian)

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

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### Participant's Authorization for Emergency Medical Treatment

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Allergies: (medications and other) \_\_\_\_\_

Medical Conditions: \_\_\_\_\_

Current Medications: \_\_\_\_\_

In the event of an emergency contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

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 Dreams Come True Therapeutic Riding Program, I authorize the Dreams Come True Therapeutic Riding Program to:

1. Secure and retain medical treatment and transportation if needed.
2. Release pertinent records upon request to the authorized individual or agency involved in the medical emergency 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 emergency contact(s) above is(are) unable to be reached.

Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parentor legal guardian)

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

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Date:

Dear Physician;

Your patient, \_\_\_\_\_ is interested in participating in supervised equestrian activities.

In order to safely provide this service, our program 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 therapeutic horseback riding. 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 Fusion/fixation  
Spinal Instability Abnormalities

NEUROLOGIC

Hydrocephalus/Shunt  
Seizure  
Spina bifida/Chiari II malformation/Tethered  
Cord/Hydromyelia

OTHER

Age – under 4 years  
Indwelling Catheters  
Medications –i.e. photosensitivity  
Poor Endurance  
Skin Breakdown

MEDICAL/PSYCHOLOGICAL

Allergies  
Animal Abuse  
Physical/Sexual/Emotional Abuse  
Blood Pressure Control  
Dangerous to self or others  
Down Syndrome  
Exacerbations of medical conditions  
Fire Settings  
Heart Conditions  
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 therapeutic equine activities, please feel free to contact the operating center at the address/phone indicated above.

## Participant's Medical History and Physician's Statement

Participant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ 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:** AtlantoDens Interval X-rays, date: \_\_\_\_\_ Result + --

Neurologic Symptoms of AtlantoAxial Instability: \_\_\_\_\_

**Please indicate current or past difficulties in the following systems/areas, including surgeries:**

|                                      | Y | N | IF YOU CHECK YES PLEASE SPECIFY |
|--------------------------------------|---|---|---------------------------------|
| AUDITORY                             |   |   |                                 |
| VISUAL                               |   |   |                                 |
| TACTILE SENSATION                    |   |   |                                 |
| SPEECH                               |   |   |                                 |
| CARDIAC                              |   |   |                                 |
| CIRCULATORY                          |   |   |                                 |
| INTEGUMENTARY/SKIN                   |   |   |                                 |
| IMMUNITY                             |   |   |                                 |
| PULMONARY                            |   |   |                                 |
| NEUROLOGIC                           |   |   |                                 |
| MUSCULAR                             |   |   |                                 |
| BALANCE                              |   |   |                                 |
| ORTHOPEDIC                           |   |   |                                 |
| ALLEGRIES                            |   |   |                                 |
| LEARNING DIASBILITY (please specify) |   |   |                                 |
| COGNATIVE                            |   |   |                                 |
| EMOTIONAL/PSYCHOLOGICAL              |   |   |                                 |
| PAIN                                 |   |   |                                 |
| OTHER                                |   |   |                                 |

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, PT, Speech, Psychologist, etc.) in the implementation of an effective equestrian program.

Name/Title: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ License/UPIN Number \_\_\_\_\_