

## Equine-assisted Therapy Participant Information Sheet

Thank you for choosing Unbridled Rehabilitation Services at the Therapeutic & Recreational Riding Center, Inc. (TRRC). In collaboration with TRRC, our primary goal is **safety**. You can help us to keep yourself and/or your child safe by following a few simple rules:

- Please arrive 15 minutes before your scheduled session to allow sufficient time to be ready for the therapist.
- **Remember to have your child wear the proper riding clothing: ASTM/SEI approved helmet, shoes with a heel and long pants. She/he must always wear an ASTM/SEI approved helmet when mounted.**
- No dangling jewelry. No perfumes, as they attract bees and biting insects.
- Please do not approach or mount the client until therapist is present and supervising.
- The relationship between the therapist and participant is very important. If your child is having any problems or has special needs, please inform the staff about it. We are here for you.
- Please do not enter stalls or allow your child, siblings, and friends to do so unless supervised by staff.
- Do not put your hands or allow your child, siblings, and friends to put hands through the bars of the stall. Horses are strong and might mistake a finger for a carrot. Please follow our “carrotting policy” and place the treat on a dish and slip it under the door.
- You are welcome to bring treats for the horses. Carrots, apples and horse cookies are all welcome; no sugar cubes or candy, please - it hurts their teeth.
- Please remind your child, siblings, and friends not to run or make loud noises in the rider support building, arena and around the horses.
- When in the observation room, do not tap on the glass – it scares the horses. Encourage children to speak, move quietly in this area – strong sounds can scare the horses.
- **Please no flash photography.** The flash may frighten the horses. Staff will be happy to take the horse outside into better lighting if time allows.
- No dogs are allowed in or around the barn and arenas (indoors or outdoors). If you bring your dog and need to walk it, please keep it on the leash and well away from the horses and riders.
- If you see anything that might be unsafe or dangerous, such as reins that are hanging loose or someone in trouble, PLEASE notify a staff member immediately.
- **We encourage all family members to be current in CPR/First Aid.** The Center has an AED (Automated External Defibrillator) – an oxygen tank is located with the AED. Staff is certified annually in its use.
- We welcome your help. If you would like to volunteer, please let us know.
- If there is anything you need, please do not hesitate to ask.

**Thank you** for your special attention and adherence to these rules.

We look forward to working with you!

## Participant Application and Health History

### GENERAL INFORMATION

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

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Weight\*: \_\_\_\_\_ Height: \_\_\_\_\_ Gender: M F \* Weight restriction of 190lbs

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

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

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

Parent/Legal Guardian: \_\_\_\_\_

Caregivers: \_\_\_\_\_

Address (if different than above): \_\_\_\_\_

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

Referral Source: \_\_\_\_\_ Phone: \_\_\_\_\_

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

### HEALTH HISTORY

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

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

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			
Other			

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_

Please list pertinent information under the appropriate heading:

**MEDICATIONS** (include prescription, over-the-counter & herbal; name, dose, and frequency): \_\_\_\_\_

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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):

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**PSYCHOSOCIAL FUNCTION** (e.g., work/school issues, grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc):

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**GOALS** (i.e., why are you applying for participation? What would you like to accomplish?):

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To my knowledge, there is no other information about the applicant that is pertinent to Unbridled Rehab, LLC, TRRC, Inc., and/or involvement of horses (mounted therapeutic activities):

\_\_\_\_\_  
Signature of Responsible Party from Page 1      Date      \*      Required Signature of 2<sup>nd</sup> Parent/Guardian      Date

\* 2<sup>nd</sup> signature is required.

If there is a special circumstance, please contact Katie Roe, Unbridled Rehab manager, to further discuss.

**It is understood** that photographs/videotapes are routinely made of riders, volunteers, staff members and other participants in the program. Unbridled Rehab along with TRRC, Inc. is hereby granted permission to make use of such photos/videos in which the rider, family or guests may appear for Unbridled Rehab and TRRC publications, presentations for public awareness, educational/research or other purposes.

#### PHOTO RELEASE

I (check one) \_\_\_ **DO** \_\_\_ **DO NOT** consent to and/or authorize the use and reproduction by Unbridled Rehab along with TRRC, Inc. 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: \_\_\_\_\_  
Participant, Parent or Legal Guardian

Participant Application and Health History – 2<sup>nd</sup> page

## Equine-assisted Therapy Contract

Participant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Hippotherapy (Camp Add-On) Fee: \$150/ 3 sessions (Monday, Wednesday, Friday)**

Payment of camp and additional services following camp will be due upon registration. If you are not including payment information on the forms, please send a check in the mail made payable to Unbridled Rehab. Riding sessions will occur following camp (12:30 - 2:30pm), so we suggest sending your child with a packed lunch on the select riding days (Monday, Wednesday, Friday).

**Please read the following terms carefully and sign at the bottom. Note this form requires signatures from both parents, unless special circumstances are noted. Thank you!**

**Medical Information & Approval for Equine-assisted Therapy:** Unbridled Rehab reserves the right to request medical histories and to make the final judgment of whether the applicant is medically able to participate in mounted equine activities. In addition, applicants/participants under age 20 with Down's Syndrome will be required to have a negative baseline x-ray.

**Prescription Medicine:** All non-emergency prescription medicine should be used before arrival at Unbridled Rehab/TRRC, Inc. Any persons (staff, volunteer, student/camper and family visitors) needing emergency medication due to a pre-existing condition, should have this noted in file by a physician. In order for Unbridled Rehabilitation Svc, LLC staff to administer emergency medication, release and emergency contact forms must be filled out and on file. Any emergency medication should be carried at all times and include specific directions.

**Representation:** Applicant and/or Responsible Party warrant and represent that applicant has no disability, impairment or ailment preventing him/her from engaging in active exercise or that will be detrimental to his/her health, safety or physical condition if he/she does so engage or participate. This representation is made by the Applicant and Responsible Party knowing that Unbridled Rehab along with TRRC, Inc. will rely upon same representation with respect to equine-assisted therapies or other activities offered.

**Apparel:** ALL PARTICIPANTS MUST WEAR A SAFETY HELMET THAT MEETS ASTM/SEI STANDARDS provided by TRRC, Inc. Proper clothing includes long pants and hard-soled shoes with a heel. Sneakers are discouraged. Unbridled Rehab staff reserves the right to inspect and approve/disapprove of gear and/or require additional gear for safety, weather and other conditions. Please consult with therapist regarding appropriate attire if further clarification is required.

**Liability:** Applicant and/or applicant's family and guests using the facilities and equipment, do so at their own risk. Unbridled Rehabilitation Services, LLC along with TRRC, Inc. shall not be liable for any damages arising from personal injuries or damages sustained in, on or about the premises. Applicant and Responsible Party assume full responsibility for any injuries or damages, and do hereby and forever, release and discharge TRRC, Inc. and its owners, employees and agents including Unbridled Rehabilitation Services, LLC from any and all claims, demands, damages, rights or causes of action, present or future, whether the same be known or unknown, anticipated or unanticipated, resulting from or arising out of the applicant's, family's, or guests' use or intended use of facilities and/or equipment.

**Weight Restriction:** For the health and safety of applicant, horse and staff, Unbridled Rehab must uphold TRRC's policy for a weight restriction of 190 pounds. All clients agree to be weighed prior to riding as a condition precedent to their participation in hippotherapy.

**Rules and Regulations:** Applicant and Responsible Party agree to abide by all rules and regulations set forth by TRRC, Inc. and Unbridled Rehabilitation Services, LLC which may be issued or amended, orally or written, at TRRC's sole discretion.

**Right of Cancellation:** Applicant or Responsible Party has the right to cancel this agreement and receive a refund of prepaid sessions within three (5) business days prior to start of camp.

\*

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Required Signature of 2<sup>nd</sup> Parent/Guardian

\_\_\_\_\_  
Date

If there is a special circumstance, please contact Katie Roe at (410) 970-2400, ext. 700 to further discuss.

## Authorization for Emergency Medical Treatment

Participant Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Primary Physician Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Co.: \_\_\_\_\_ Policy # \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Current medications: \_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Alt. Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Alt. Phone #: \_\_\_\_\_ **[Select Consent OR Non-Consent plan below and sign]**

**CONSENT PLAN:** In the event emergency medical aid or treatment is required due to illness or injury while receiving services or while on the property of TRRC, Inc., I authorize Unbridled Rehabilitation Services, LLC and/or TRRC, Inc. to:

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

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician or emergency personnel. This provision will only be invoked if the person(s) above is unable to be reached:

Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Rider, Parent or Legal Guardian

Printed Name of Above: \_\_\_\_\_ Phone # \_\_\_\_\_

**NON-CONSENT PLAN:** I do not give my consent for emergency medical treatment/aid in the case of illness or injury while receiving services from Unbridled Rehabilitation Services, LLC or while on the property of TRRC, Inc.

\_\_\_ Parent, legal guardian or caretaker will remain on site at all times during equine assisted activities

\_\_\_ In the event emergency treatment/aid is required, I wish alternate procedures to take place:

Non-Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Rider, Parent or Legal Guardian

Printed Name of Above: \_\_\_\_\_ Phone # \_\_\_\_\_

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

Dear Health Care Provider:

Your patient \_\_\_\_\_  
(Participant's name)

is interested in participating in equine assisted activities facilitated by a state licensed therapist.

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 according to the governing bodies of our practices, namely, the American Hippotherapy Association and Professional Association of Therapeutic Horsemanship International. 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  
Coed/Hydromyelia

**Other**

- Age - under 2 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 activities, please feel free to contact us at the address/phone listed below.

Sincerely,

Unbridled Rehabilitation Services, LLC  
(410) 970-2400  
info@unbridledrehab.com



## Medical History and Physician's Referral

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

**Diagnosis Code: ICD-10** \_\_\_\_\_

Past/Prospective Surgeries: \_\_\_\_\_

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

Seizure type: \_\_\_\_\_ Controlled: Y N Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_ Date of last: \_\_\_\_\_

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: \_\_\_\_\_

*Unbridled Rehabilitation Services requires that individuals with Down syndrome be fully examined annually for atlantoaxial instability. Once a negative baseline is established, further X-rays are at the discretion of the parents and physician.*

Date of X-rays: \_\_\_\_\_ Radiologist: \_\_\_\_\_ Results: + -

Neurological symptoms of Atlanto-Axial Instability:  Present  Absent

Please indicate any special needs/concerns:	Yes	No	Comments (if necessary, continue on back)
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies (i.e. asthma, bee sting, dust)			
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 and/or therapies. I understand that Unbridled Rehabilitation Services LLC, providing services at the PATH Intl. accredited center, TRRC, Inc., will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Unbridled Rehabilitation Services for ongoing evaluation to determine eligibility for participation. **(PLEASE INCLUDE PRESCRIPTION FORM for PT/OT/SLP appropriate for the specific type of therapy to be provided)**

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

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

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

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

## Confidentiality Policy and Agreement

Unbridled Rehabilitation Services, LLC along with TRRC, Inc. shall preserve the right of confidentiality for all individuals in its program. Any and all full and part-time staff, independent contractors, temporary employees, volunteers, and others, shall keep confidential all medical, social, referral, personal, and financial information regarding a person and his/her family.

Unbridled Rehab recognizes that a participant or his/her family members may not have legal authority to disseminate information, whether due to age or mental capacity. As a general rule, infants and children under the age of 18 years DO NOT have legal authority to consent to disclosure. Only parents, legal guardians, or others (as defined by the state statute) have this authority. Adults with developmental disabilities are presumed legally competent to give or deny disclosure unless they have been adjudicated incompetent to make this type of health care decision. If a substitute decision-maker has been appointed, Unbridled Rehabilitation Services LLC, and its representatives, must obtain specific and informed written consent from that individual.

The policy extends to all situations involving Unbridled Rehabilitation Services LLC and its clients, whether or not any information was disseminated accidentally or on purpose.

Unbridled Rehabilitation Services, LLC shall not disseminate to its employees or others, knowledge of a person's medical or sensitive information unless there is a risk to others through casual contact and permission has been obtained.

Unbridled Rehabilitation Services, LLC shall reserve the right to use universal precautions for all situations in which staff may be exposed to the blood of a client. Unbridled Rehabilitation Services, LLC shall act under the assumption that all clients may have a blood borne disease. Such actions do not indicate a breach of confidentiality, but rather a general policy for use in all situations in which persons are exposed to another's blood.

Unbridled Rehabilitation Services, LLC shall only disclose information to outside agencies/individuals with the specific written consent of the client/legal representative. In cases of medical emergency due to illness or injury while receiving services rendered by Unbridled Rehabilitation Services, LLC or while on the property of TRRC, Inc., this policy shall recognize to the required Authorization for Emergency Medical Treatment as such required written consent.

Any breach of the above confidentiality policy by staff, volunteers, and other persons will result in:

- 1) a documented verbal warning;
- 2) a formal written reprimand;
- 3) dismissal.

### Confidentiality Statement

*By signing below, I certify that I understand and will observe the confidentiality policy of Unbridled Rehabilitation Services, LLC.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature / URS staff

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name







**TRRC Fire Evacuation Procedure**

Because we are on the premises of TRRC, we must abide by their policy and procedures in the occurrence of an emergency situation to maintain a safe environment. Please read TRRC fire evacuation procedure below and sign at the bottom. Thank you.

**When the FIRE ALARM sounds:**

- All riders and family members must immediately and orderly exit the Rider Support Building, stalls or arena and proceed to the **flag court** at the top of the hill. Delay in exiting the building could interfere with trained staff assisting riders needing support, and the horses.
- Exit the building at the nearest **EXIT** (marked with the red EXIT sign and a spot light).
- All riders on the trails will dismount and remain in radio contact to await further instruction.
- Do NOT return into any building, stall or arena again for ANY REASON.
- A senior staff member has been assigned to sweep the building and assure that every single person is out of the building and all rooms are vacated. Once the building has been checked, the staff will be able to assist with the horses.
- Do NOT go into any of the riding arenas or stalls to help the staff, or to retrieve riders or horses. The staff has been trained on the proper emergency evacuation procedures and will join family members at the flag court. NO HORSES WILL BE RESCUED UNTIL ALL PEOPLE ARE SECURED SAFELY.
- Do NOT attempt to assist with the horses. They could become very unpredictable and dangerous with all of the activity, noise and smells. Allow only trained staff members to work with the horses.
- Do NOT drive away from TRRC when the fire alarm sounds even if you have your rider. Moving vehicles will add to the confusion and are too dangerous with all of the movement of people and horses.
- All vehicles and debris must stay clear of the fire lanes and driveway to allow access by Emergency Vehicles.
- Once the "All Clear" is given, staff, riders, and family members can proceed back to the buildings for normal operations.

***Thank you for following these life-saving procedures to assure the safety of our loved ones, both human and animal.***

**By signing below, I agree to the Fire Evacuation Procedures**

\_\_\_\_\_  
Participant/Guardian Signature Date

\_\_\_\_\_  
Printed Name of Participant/Guardian