Participant's Medical History & Physician's Statement

Participant: _____

DOB: _____ Height: _____ Weight: _____

Address: _____

City _____ State_____Zip_____

Gender: M F

Alternative #: _____

Employer/School:_____

Address:_____Phone:_____

Parents/Legal Guardians:_____

Phone: _____ Email: _____

Caregivers:_____Phone:_____

Address (if different from above):_____

How did you hear about the program?_____

Diagnosis: _____ Date of Onset:_____

Past/Prospective Surgeries:

_____

_____

Medications:(include prescription and over-the-counter; name, dose and frequency)

_____

Seizures: Y N 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 Atlanto Axial Instability:_____

PHYSICAL FUNCTION (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

Comments:_____

_____

PSYCHO/SOCIAL FUNCTION (e.g.,. work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

Comments:_____

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

Comments:_____

Please indicate current or past special needs in the following systems/areas, including surgeries:

Auditory Y N Comments :_____

Visual Y N Comments :_____

Bone/Joint Y N Comments :_____

Tactile Sensation Y N Comments :_____

Speech Y N Comments :_____

Cardiac Y N Comments :_____

Circulatory Y N Comments :_____

Integumentary/Skin Y N Comments :_____

Immunity Y N Comments :_____

Pulmonary Y N Comments :_____

Neurologic Y N Comments:_____

Muscular Y N Comments :_____

Balance Y N Comments :_____

Orthopedic Y N Comments :_____

Allergies Y N Comments :_____

Learning Disability Y N Comments :_____

Cognitive Y N Comments :_____

Behavioral Y N Comments :_____

Emotional/Psychological Y N

Comments :_____

Pain Y N Comments :_____

Muscular Y N Comments :_____

Other Y N Comments :_____

Clients with questionable health conditions that may preclude them to ride a horse (spinal, head, neck, or other) need to have this Physicians statement signed:

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 Dream Power Therapy will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Dream Power Therapeutic Equestrian Cneter for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: (_____) License/UPIN Number: _____

PHOTO RELEASE

I □ DO

□ DO NOT

consent to and authorize the use and reproduction by Dream Power Therapeutic Equestrian Center, 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: _____

Client, Parent or Legal Guardian

Authorization for Emergency Medical Treatment Form

O Participant O Staff O 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: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

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 Dream Power Therapeutic Equestrian Center, Inc. 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 treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency.
O Parent or legal guardian will remain on site at all times during equine-assisted activities.

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

_____

_____

_____

Date: _____

Non-Consent Signature: _____

Client, Parent or Legal Guardian