Champlain Adaptive Mounted Program

Participant's Application & Health History

Participant: _____

DOB:_____ Age:_____ Height:_____ Weight:_____ (limit 190 lbs) M F

Address: _____

Phone:_____ E-mail:_____ Cell #:_____

Employer/School:_____

Address:_____

Phone: _____

Parent/Legal Guardian/Caregivers: _____

Address (if different from above): _____

Phone:_____

Referral Source: _____

Phone: _____

How did you hear about the program? _____

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			

Champlain Adaptive Mounted Program

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: _____

LIABILITY RELEASE

Participant's Name:_____would like to participate in *CHAMP* – Champlain Adaptive Mounted Program. I acknowledge the risks and potential for risks of horseback riding, however I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risks 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 *CHAMP – CHAMP* at Good Hope Farm, its board of directors, instructors, therapists, volunteers and/or employees, and PATH International from any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in *CHAMP* activities. I also understand that under Vermont law, an equine activity sponsor is not liable for an injury to, or the death of a participant in equine activities resulting from the inherent risks of equine activities that are obvious and necessary, pursuant to 12 V.S.A. 1039

SIGNATURE:_____DATE:_____

Print name below if signature is by a parent or guardian – for participants under age 18

_____Relationship_____

Champlain Adaptive Mounted Program

CHAMP may request you to be part of a promotional press release. For legal reasons we require that you understand and agree to the releases below by filling them out and signing both.

*PARTICIPANT*_____*: DATE OF BIRTH:* _____*AGE:*_____

*ADDRESS:*_____

*CITY / STATE/ ZIP*_____

*HOME PHONE*_____ *WORK PHONE:*_____

PHOTO RELEASE
❑I Do
❑I Do Not

consent to and authorize the use and reproduction by *CHAMP* of any and all photographs and any other audio-visual materials taken of me/my son/my daughter/my ward for promotional use, educational activities, and exhibitions or for any other use for the benefit of the program.

SIGNATURE _____ ***DATE*** _____
PRINT NAME BELOW IF SIGNATURE IS BY A PARENT OR GUARDIAN RELATIONSHIP

_____ ***Relationship***_____

INFORMATION FOR PRINT RELEASE
❑I Do
❑I Do Not

consent to and authorize the use and reproduction of any and all interviews done by members of the press for the purposes of promoting the Champlain Adaptive Mounted Program - *CHAMP*. I will not hold any *CHAMP* instructor or volunteer or the authors or publishers of any article liable for statements they may make about me and my participation in this program based on the information provided in interviews. I further understand that I am participating solely for the promotion and fundraising to benefit the *CHAMP* programs and that there will be no compensation made to me by *CHAMP* or the publishing organizations.

SIGNATURE_____ **DATE**_____
PRINT NAME BELOW IF SIGNATURE IS BY A PARENT OR GUARDIAN RELATIONSHIP

_____ ***Relationship***_____

Champlain Adaptive Mounted Program

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: _____ 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 CHAMP 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
Signed in presence of center staff

Champlain Adaptive Mounted Program

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: _____

_____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/ Assistive Devices:_____

For those with Down Syndrome: Neurologic Symptoms of Atlanto Axial Instability: _____ Present _____ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions May 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			
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 ***CHAMP*** will weigh the medical information en against the existing precautions and contraindications. Therefore, I refer this person to ***CHAMP*** for aluation to determine eligibility for participation.

/Name/ Title: _____ MD DO NP PA Other_____

Signature: _____ Date: _____

Address:_____

Phone: (___)_____License/UPIN Number: _____

Champlain Adaptive Mounted Program

Participant's Health Care Update

Date: _____

Dear Health Care Provider:

Your patient, _____
(participant's name)

has been participating in supervised equine activities at: ***Champ - Champlain Adaptive Mounted Program*** 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, hospitalizations, changes in medications, treatment, weight, or behavior. Please indicate current height/weight. For your reference, potential precautions/contraindications are listed on the reverse.

Diagnosis:_____

Height:_____ Weight: _____(weight limit to ride 190 lbs)

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

Name/Title: _____MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

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

Date: _____

Champlain Adaptive Mounted Program

Dear Health Care Provider:

Your patient, _____
(participant's name)
is interested in participating in supervised equine activities.

In order to safely provide this service, *CHAMP* 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
MalformationlTethered Coed/Hydromyelia
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

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

Neurologic
Hydrocephalus/Shunt
Seizure
Spina BifidaiChiari IT

Other
Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - i.e. Photosensitivity
Poor Endurance
Skin Breakdown
Weight over 190 lbs

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 Champ at the address/phone indicated above.