CHAMPLAIN ADAPTIVE MOUNTED PROGRAM

57 East Shore Road, South Hero, VT 05486

Participant's Application and Health History

Participant: _____

DOB: _____ Age:_____ Height_____ Weight_____(Limit 160lb) M F

Address: _____

Phone: _____ Email: _____ 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: _____

Current or past special needs	Y/N	Comments
Vision		
Hearing		
Sensation		
Communication		
Heart		
Breathing		
Digestion		
Elimination		
Circulation		
Emotional/Mental Health		
Behavioral		
Pain		
Bone/ Joint		
Muscular		
Thinking / Cognition		
Allergies		

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

_____

_____

_____

Describe the participants abilities / difficulties. Include assistance required or equipment needed:

Physical Function (i.e.., mobility skills such as transfers, walking, wheelchair use, driving /bus riding)

_____

_____

_____

Psycho/Social Function (e.g. ,work / school including grade completed, leisure interests, relationships, family structure support systems, companion animals, fears/ concerns)

_____

_____

_____

Goals (i.e., why are you applying? What would you like to accomplish?)

_____

_____

_____

Signature: _____ Date: _____

Liability Release

Participant's Name: _____ would like to participate in the 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 at Good Hope Farm, its board of directors, instructors, therapists, volunteers and/or employees; and PATH International; for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Equine 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

_____

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Dear Health Care Provider:

Your patient, _____(*participant's name*) is interested in participating in 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 Malformation Tethered Coed/Hydromyellia 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 Through 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 160 lbs

Thank you very much for your assistance. If you have any questions or concerns requiring this patient's participation in equine assisted activities, please feel free to contact CHAMP.

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Participant's Health Care Update

Date:_____

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 of 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 160 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: _____

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Participant Medical History & Physician's Statement

Participant: _____ DOB: _____Height_____Weight_____

Address: _____

Diagnosis: _____

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.

Condition	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 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: _____

CHAMPLAIN ADAPTIVE MOUNTED PROGRAM

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Authorization for Emergency Medical Treatment

Name: _____ DOB:_____Phone :_____

Address: _____

Physician's Name: _____Preferred Medical Facility _____

Health Insurance Company: _____Policy No._____

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 on the property, I authorize Champ at Good Hope Farm (Champ) to:

- Secure and retain medical treatment and transportation, if needed,
- 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 or emergency medical personnel.

This provision will only be invoked if the Emergency Contact persons above are unable to be reached.

Signature of Parent/Guardian: _____ Date: _____

CHAMPLAIN ADAPTIVE MOUNTED PROGRAM

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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: _____DOB:_____Age:_____

Address:_____

Home Phone:_____

Work Phone:_____

Cell Phone:_____

PHOTO RELEASE

- ☐ I do
- ☐ I do not

consent to and authorize the use and preproduction 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 and for any other use for the benefit of the program.

SIGNATURE_____Date:_____

Name: _____Relationship_____

Print name above if signature is by a parent or guardian relationship

INFORMATION FOR PRINT RELEASE

- ☐ I do
- ☐ I do not

consent to and authorize the use and reproduction by CHAMP of any and all interviews done by members of the press for 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:_____

Name: _____Relationship_____

Print name above if signature is by a parent or guardian relationship