Stable Hands
Equine Therapy Center

Mailing address:
225780 Rib Mountain Drive PMB 243
Wausau, WI 54401

Phone : (715) 359-6046
e-mail: dabitz@stablehandstherapy.com
www.stablehandstherapy.com

Dear Parents/Student/or Guardian,

The following forms need to be completed and returned to the above address as soon as possible for us to be able to review each student for equine therapy.

For you to fill out:

- Participant's Application & Health History- page 1 & 2
- Liability Release- page 3-A

Give to Physician:

Filled out by you: Participants Consent for Release- page 3

To be completed by Physician:

- Conditions & Contraindications- pages 4
- Medical History- page 5

I look forward to seeing you when class starts. If you have any questions, please do not hesitate to call or email me.

Sincerely,

Diane Abitz
Executive Director/Program Director
715-359-6046 office /715-302-2484 cell
dabitz@stablehandstherapy.com

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PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Participant's Application & Health History

GENERAL INFORMATION

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____

Phone: _____ Email: _____ Alternative #: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Caregivers: _____

Address (if different from above): _____

Phone: _____

Payment Source: iLife____ Childrens LTS_____Social Services____Inclusa_____Lakeland Care_____ Personal Pmt_____

Caseworker: _____ Phone Number: _____ Email: _____

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			

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

_____

_____

_____

_____

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

PHYSICAL FUNCTION (e.g., transfers, walking, wheelchair use, driving/bus riding, weaknesses)

Mobility:_____

_____

Motor skills:_____

_____

_____

PSYCHOSOCIAL FUNCTION

Interests: _____

_____

Dislikes/fears: _____

Support systems/family structure/companion animals:

_____

_____

Job/grade, etc.: _____

GOALS (why are you applying for participation? What would you like to accomplish?)

Physical: _____

Educational: _____

Social: _____

Life: _____

Signature: _____ Date: _____

PHOTO RELEASE

I ☐ DO

☐ DO NOT

consent to and authorize the use and reproduction by _____

(center)

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

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dabitz@stablehandstherapy.com

Participant's Consent for Release

I hereby authorize: _____
(person or facility)

to release information from the records of: _____ DOB: _____
(participant's name)

The information is to be released to: Stable Hands Equine Therapy Center
(center or therapist's name)

for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

- ☐ Medical history
- ☐ Physical therapy evaluation, assessment and program plan
- ☐ Speech therapy evaluation, assessment and program plan
- ☐ Mental health diagnosis and treatment plan
- ☐ Individual Habilitation Plan (IHP) Classroom
- ☐ Individual Education Plan (IEP) Psychosocial
- ☐ evaluation, assessment and program plan Cognitive-
- ☐ behavioral management plan
- ☐ Other: _____

This release is valid for one year and can be revoked, in writing, at my request.

Signature: _____ Date: _____

Print Name: _____

Relation to Participant: _____

Please send materials to: Stable Hands Equine Therapy Center

Mailing address: 225780 Rib Mountain Drive PMB 243

Wausau, WI 54401

Or email to: dabitz@stablehandstherapy.com

Stable Hands
Equine Therapy Center

LIABILITY RELEASE

_____ (Rider's name) would like to participate in the Stable Hands program. I acknowledge the risks and potential for risks of horseback riding and horse related activities. However, I feel the possible benefits to myself/my son/my daughter/my ward are greater than the risk 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 Stable Hands, Inc., its Board of Directors, Instructors, Therapist Consultant, Equine Manager/Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in the Stable Hands program.

Signature _____ Date_____

Client, Parent or Guardian

RIDER'S AUTHORIZATION/EMERGENCY MEDICAL TREATMENT

In the event of an 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 Stable Hands 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.

IN CASE OF AN EMERGENCY CONTACT:

_____PHONE_____

OR CONTACT_____PHONE_____

Physician's Name_____

Preferred Medical Facility_____

Health Insurance Co._____

Policy #_____

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 person below is unable to be reached.

Date _____Print Name _____Phone_____

Consent Signature_____

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PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Date: _____

Dear Health Care Provider:

Your patient _____
(participant's name)

is interested in participating in supervised equine activities.

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. 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 4 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 the center at the address/phone indicated above.

Sincerely,

Name *Center Name* *Phone Number*

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 Atlantoaxial 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.

Areas	Y	N	Comments
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Auditory			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			

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

Name/Title: _____ MD DO NP PA Other

Signature: _____ Date: _____

Address: _____

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