Stable Hands
Equine Therapy Center

Mailing address:
3501 Swan Ave.
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

Stable Hands
Equine Therapy Center

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3501 Swan Ave., Wausau, WI 54401
(715) 359-6046 dabitz@stablehandstherapy.com

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Participant's Application & Health History

GENERAL INFORMATION

Participant: _____ Date: _____

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

Address: _____

Phone: _____ Email: _____ Alternative #: _____

Employer/School: _____ Grade: _____

Address: _____

Phone: _____

Parent(s)/Legal Guardian: _____

Siblings: _____

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			

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: _____

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

I 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

Stable Hands
Equine Therapy Center

3501 Swan Ave.
Wausau, WI 54401
(715) 359-6046
dabitz@stablehandstherapy.com

PATH
INTERNATIONAL

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: 3501 Swan Ave.

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_____

Stable Hands
Equine Therapy Center

Mailing address:
3501 Swan Ave.
Wausau, WI 54401
(715) 359-6046

PATH 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*

StableHands, Inc.
Equine Therapy Center

Mailing address:
3501 Swan Ave.
Wausau, WI 54401

www.stablehandstherapy.com

NAME: _____ DATE OF BIRTH _____

ADDRESS: _____

NAME OF PARENT/GUARDIAN _____

DIAGNOSIS _____ DATE OF ONSET_____

******FOR PERSONS WITH DOWN SYNDROME:***

_____ NEGATIVE CERVIVAL X-RAY FOR ATLANTOAXIAL INSTABILITY. X-RAY DATE_____

_____ NEGATIVE FOR CLINICAL SYMPTOMS OF ATLANTOAXIAL INSTABILITY.

TETNUS SHOT: Yes____ No____ Date_____ Height _____ Weight_____ Seizure Type_____

Controlled _____ Date of Last Seizure _____ Medications_____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Crutches ___Yes ___No - Braces ___Yes ___No - Wheelchair ___Yes ___No - Special Precautions?_____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of the person's abilities/limitations by a licensed/credentialed health professionals in the implementing of an effective equestrian program.

Physician Name (Please print)_____Date _____Phone _____

Physicians Signature_____

Address_____City_____State_____ Zip_____