** STUDENT APPLICATION FORM**

**(THIS FORM MUST BE COMPLETED IN FULL AND ORIGINAL RETURNED TO GREAT PRIOR TO PARTICIPATION)**

**GREAT RESULTS EQUINE ASSISTED THERAPIES**

**7141 Greenwood-Springridge Road**

**Greenwood, LA 71033**

**318-938-9166**

 DATE:

NAME: Birth Date:

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY/STATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ZIP: EMAIL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME NO: ( ) WORK NO: ( ) \_\_\_\_\_ CELL NO: ( )

SCHOOL OR OTHER EDUCATIONAL INSTUTUTION ATTENDING:

DIAGNOSIS: WEIGHT: HEIGHT:

IF UNDER AGE 18, NAME OF PARENT/GUARDIAN:

WORK PLACE: WORK PHONE:

IN CASE OF EMERGENCY, NOTIFY: HOME PHONE:

 RELATIONSHIP: WORK PHONE:

 ADDRESS:

PHYSCIAN: PHONE:

HOSPICAL & TOWN PREFERRED:

I AM/MY CHILD IS: AMBULATORY NON-AMBULATORY VERBAL NON-VERBAL

I USE/MY CHILD USES: WHEELCHAIR CRUTCHES BRACES OTHER

I/MY CHILD: CAN CANNOT SIT INDEPENDENTLY.

I WOULD LIKE TO APPLY FOR A SCHOLARSHIP: YES NO

IN CASE OF EMERGENCY, I GIVE PERMISSION TO GREAT RESULTS EQUINE ASSISTED THERAPIES, INC. TO SECURE MEDICAL TREATMENT, INCLUDING X-RAY, SURGERY, HOSPITALIZATION, AND MEDICATION.

 DATE:

STUDENT SIGNATURE, OR IF UNDER 18, PARENT/GUARDIAN SIGNATURE

Make check payable to: GREAT RESULTS EQUINE ASSISTED THERAPIES, INC.

FOR OFFICE USE ONLY

Date Application Received: Date Student Began Riding:

**STUDENT LIABILITY RELEASE**

I, undersigned adult student, or parent or guardian of , a minor student, would like to participate at Great Results Equine Assisted Therapies, Inc. (hereinafter referred to as GREAT.) I acknowledge the risks and potential for risks of horseback riding. I understand that I/my son/ daughter/ ward, will be working with and around horses, as well as riding horses of GREAT, however I feel that the possible benefits of myself/son/daughter/ward are greater than the risk assumed. I, the undersigned student and/or parent or guardian, hereby, intending to be legally bound, for myself, my heirs, and assigns, executors or administrators, waive and forever release, acquit, discharge and hold harmless, all claims for damages against GREAT, it’s board of directors, trustees, agents, instructors, therapists, employees, representatives, successors, assigns, volunteers, owners of the property on which GREAT operates, for any and all manner of claims, demands and damages of every kind or nature whatsoever, which student may now, or in the future have against GREAT, it’s board of directors, trustees, agents, instructors, therapists, employees, representatives, successors, assigns, volunteers, owners of the property on which GREAT operates, successors or assigns on account of any personal injuries and/or personal damages known or unknown, or in any way growing out of, the acts of GREAT, it’s board of directors, trustees, agents, instructors, therapists, employees, representatives, successors, assigns, volunteers, owners of the property on which GREAT operates, successors or assigns.

I understand that Great Results Equine Assisted Therapies, Inc. (hereinafter referred to as GREAT) is a FARM ANIMAL ACTIVITY SPONSOR WITHIN THE MEANING OF LOUISIANA REVISED STATUTE SECTION 9:2795.1, WHICH PROVIDES:

**Under Louisiana Law, a farm animal activity sponsor or farm animal professional is not liable for an injury to the death of a participant in a farm animal activity resulting from the inherent risks of the farm animal activity, pursuant to R.S. 9:2795.1.**

Student Signature Date

If under 18 years, Parent or Guardian Signature Date

**GREAT**

**RIDER’S AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM**

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 GREAT RESULTS EQUINE ASSISTED THERAPIES 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.

Client’s Name: Phone:

Address:

In the event I cannot be reached, Contact: Phone:

 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: Consent Signature:

 Client, Parent, or Guardian

Print Name: Phone:

Address:

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

Date: Non-Consent Signature:

 Client, Parent, or Guardian

Print Name: Phone:

Address:

**THE ORIGINAL COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM.**

**(PLEASE, NO XEROX’S, FAXES, OR OTHER COPIES PERMITTED.)**

**GREAT RESULTS EQUINE ASSISTED THERAPIES**

**PHOTO RELEASE**

For valuable consideration given, which is hereby acknowledged, the undersigned hereby in grants to Great Results Equine Assisted Therapies, Inc. (hereinafter referred to as GREAT), permission to take or have taken still and moving photographs and films including television pictures of (name) and consents/authorizes GREAT, it’s advertising agencies, news media, and any other person interested in GREAT and it’s work, to use and reproduce the photographs, films, and pictures and to circulate and publicize the same by all means including, but not limited to, newspapers, television media, brochures, pamphlets, instruction material, books and clinical material.

With respect to the foregoing matters, no inducements or promises have been made to us/me to secure our/my signatures to this release other than the intention of GREAT to use or cause, to be used, such photographs, films and pictures for the primary purpose of promoting and aiding GREAT and it’s work.

Student Signature, or if under 18 years, Parent or Guardian Signature Date

NON-CONSENT

I do not give my consent to Great Results Equine Assisted Therapies, Inc. to take, or have taken, still and/or moving photographs and films, including television pictures.

Student Signature, or if under 18 years, Parent or Guardian Signature Date

**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.***

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No |  Comments |
| Auditory |  |  |  |
| Visual |  |  |  |
| Tactile Sensation |  |  |  |
| Speech |  |  |  |
| Cardiac |  |  |  |
| Circulatory |  |  |  |
| Integumentary/Skin |  |  |  |
| Innumity |  |  |  |
| Pulmonary |  |  |  |
| Neurologic |  |  |  |
| Muscular |  |  |  |
| Balance |  |  |  |
| Orthopedic |  |  |  |
| Allergies |  |  |  |
| Learning Disabilities |  |  |  |
| 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 the PATH Intl. Center, Great Results Equine Assisted Therapies (GREAT), will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to GREAT for ongoing evaluation to determine eligibility for participation.

Name/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD DO NP PA Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_License/UPIN Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Medical/Psychological**

Atlantoaxial Instability - include neurologic symptoms Allergies

Coxarthrosis Animal Abuse

Cranial Defects Cardiac Condition

Heterotopic Ossification/Myositis Ossificans Physical/Sexual/Emotional Abuse

Joint subluxation/dislocation Blood Pressure Control

Osteoporosis Dangerous to Self or Others

Pathologic Fractures Exacerbations of Medical Conditions (e.g., RA, MS)

Spinal Joint Fusion/Fixation Fire Setting

Spinal Joint Instability/Abnormalities Hemophilia

Medical Instability Migraines

PVD

Recent Surgeries

**Neurologic**  Respiratory Compromise

Hydrocephalus/Shunt Thought Control Disorders

Seizure Weight Control Disorder

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

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,

Caroline Hendrix, Director of Great Results Equine Assisted Therapies (GREAT)

(318) 938-9166

(318) 938-1181 Fax

Chendrix@thearccaddobossier.org