



Windrush Farm Therapeutic Equitation, Inc.

30 Brookview Road
Boxford, MA 01921
www.windrushfarm.org
978-682-7855

Participant's Application, Photo Release, and Health History

GENERAL INFORMATION:

Participant's Name: _____
DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F
Address Street: _____ City: _____ State: _____ Zip: _____
Home #: _____ Cell # /Work#: _____ E-mail: _____
Employer/School: _____ Phone: _____
Address: _____
Parent/Legal Guardian/Caregiver: _____
Address (if different from above): _____
Phone #: _____ Alternative #: _____

If you are a new applicant:

How did you hear about our program? _____
If referred, please list source and date: _____
If you have any previous riding/horse experience, please describe: _____

If you currently ride at W.F.T.E., Inc. please list start date: _____

PHOTO RELEASE:

I DO / DO NOT (**please circle one**) consent to and authorize the use and reproduction by Windrush Farm Therapeutic Equitation, Inc. of any and all photographs and any other audio/visual materials taken of me/my son/daughter/ward for promotional materials, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____
Participant (Parent or Legal Guardian)

RIDING GOALS: (What you would like to accomplish during your time with us.)

Short Term (During the next 6–12 months): _____

Long Term (During the next 2-3 years): _____

OTHER GOALS: (This could include social, recreational, professional/career, etc.)

AREAS OF FOCUS/STRENGTHS/WEAKNESSES

Riding a horse involves many aspects of the whole person; the physical, cognitive, and emotional. Participating in riding lessons adds even more dimensions to the scenario, such as our learning styles, spatial awareness, social interactions, etc. Please use this section to discuss information that you believe might be helpful or issues that you would like addressed, so that the instructor can create a beneficial, supportive lesson environment for you/your child. A good place to start might be the teaching environment, aids, and tools that best supports your learning style and needs. _____

MISC. HEALTH ISSUES

Please include any health issues (i.e. allergies, asthma, reactions to medications, dizziness, etc.) that you feel staff should be aware of.

PREFERENCES

Although the needs and requirements of all our riders is the priority, every effort is made to accommodate the preferences of our riders. Toward that goal, please feel free to share with us your “favorites” in horses and tack. It would be beneficial if you would explain why you prefer a certain horse or piece of equipment so that, if we can not exactly meet your wishes, we can come close. _____

CONCERNS

This could include any past riding experiences that caused a loss of confidence, any conditions or circumstances that you feel could interfere with your ability to ride safely or to your full potential, any fears, etc, _____

Lessons at Windrush are a team effort. Your instructor wants and appreciates your input throughout the riding session. Please feel free to ask questions, make suggestions, and give feedback. Discussions of any length can be done on the phone or via e-mail. Each instructor and staff member has an e-mail address for your convenience.

First name@windrushfarm.org

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; (include assistance required or adaptive equipment needed):

PHYSICAL FUNCTION (i.e. Mobility skills such as transfer, walking, wheelchair use): _____

COGNITIVE/LEARNING SKILLS (i.e. Learning Disabilities, communication aids or tools): _____

PSYCHO/SOCIAL FUNCTION (i.e. Work/school, behavior/safety issues, relationship-family structure, support systems, fears/concerns. etc.): _____

Signature: _____ **Date:** _____

Participant (parent or guardian)



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Participant's Authorization for Emergency Medical Treatment Form

Participant's Name: _____ DOB: _____ Phone: _____
Address: _____
Family Email Address: _____

In the event of an emergency, contact;
Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Physician's Name _____ Telephone _____
Preferred Medical Facility: _____
Health Insurance Co.: _____ Policy #: _____

Allergies to medications: _____

Current medications: _____

State any information that you want supplied to a medical professional treating you in an emergency: _____

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 premises operated by Windrush Farm Therapeutic Equitation, Inc., I authorize Windrush Farm Therapeutic Equitation, Inc. 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 below is unable to be reached.

Date: _____ Consent Signature: _____

Participant (Parent or Guardian if participant is under the age of 18 yrs)

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. Therefore, check one of the following:

_____ *A parent or legal guardian will remain on site at all times during equine assisted activities.*

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

Date: _____ Non-Consent Signature: _____

Participant (Parent or Guardian if participant is under the age of 18 yrs)

Print Name: _____ Phone: _____

Address: _____

UNDER MASSACHUSETTS LAW, AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO, OR THE DEATH OF, A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES, PURSUANT TO CHAPTER 128-SECTION 2D OF THE GENERAL LAWS.