



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.



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MEDICAL REVIEW FORM

Date: _____

Dear Health Care Provider:

Your patient, _____

has been participating in an equine activities program at **Windrush Farm Therapeutic Equitation, Inc.** 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, and changes in medication, treatment, weight or behavior. Please indicate current height /weight. For your reference, potential precautions/contraindications are listed on the next page.

Diagnosis: _____

Height: _____ Weight: _____

Update Status: _____

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the NARHA center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Name/title: _____ MD DO NP PA Other _____
Signature: _____ Date: _____
Address: _____
Phone: () _____ License/UPIN Number: _____

Information for Physician

The following conditions, if present, may represent precautions or contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact us at (978) 682-7855.

Orthopedic

Spinal Joint Fusion/Fixation
Spinal Joint Instabilities/Abnormalities
Atlantoaxial Instabilities – include neurologic symptoms
Scoliosis
Kyphosis
Lordosis
Joint Subluxation/Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification/Myositis Ossificans
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Neurologic

Hydrocephalus/shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Seizure Disorders
Paralysis due to Spinal Cord Injury

Medical/Psychological

Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Cardiac Condition
Stroke (Cerebrovascular Accident)
Animal Abuse
Physical/Sexual/Emotional Abuse
Fire Setting
Danger to self or others
Thought/Weight Control Disorders
Exacerbations of medical conditions
(i.e. RA, MS)
Medical Instability
Migraines
Respiratory Compromise
Substance Abuse

Secondary Concerns

Behavior problems
Age under four years
Poor Endurance
Acute exacerbation of chronic disorder
Indwelling Catheters/Medical Equip.
Skin Breakdown
Medications – i.e. photosensitivity

**WINDRUSH FARM THERAPEUTIC EQUITATION, INC.
PHYSICAL or OCCUPATIONAL THERAPY EVALUATION**

Please complete all applicable areas

Date: _____ **Name:** _____

Height: _____ **Weight:** _____ **Age:** _____

Diagnosis: _____

Seizures: _____

Medications: _____

Reflexes: _____

Tone: _____

ROM: _____

Posture: _____

Balance: _____

Mobility: _____

Gait (where applicable): _____

Senses/Sensation: _____

Circulation: _____

Development Motor Sequence Activities (where applicable): _____

ADLs: _____

Communication: _____

Equipment/Aids: _____

Additional Notes: _____

Precautions: _____

Therapist's Signature (a registered PT or OT must sign)

I am currently not under the care of a P.T. or O.T. I will notify you if that changes.

Participant's Signature (parent/guardian)