**Participant’s Intake Application and Health History**

**GENERAL INFORMATION**

Participant Name

DOB Age Height Weight\* Gender: M F

Address

Phone Alternative # E-mail

Employer/School

Address

Phone

Parent/Legal Guardian

Address (if different from above)

Phone (if different from above)

Caregivers

Phone

Referral Source

Phone

How did you hear about the program?

**GOALS** (i.e. why are you applying for participation? What would you like to accomplish?

*\* Weight confirmed on site. Maximum weight allowance 180 lbs. dependent on muscle tone.*

**HEALTH HISTORY**

Diagnosis Date of Onset

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

***Please check all current and/or past special needs in the following areas:***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Special Needs*** | ***Please check*** | ***Comments*** | ***Special Needs*** | ***Please check*** | ***Comments*** |
| Vision |  past € current |  | Sensation |  past € current |  |
| Heart |  past € current |  | Digestion |  past € current |  |
| Circulation |  past € current |  | Behavioral |  past € current |  |
| Emotional orMental Health  |  past € current |  | Thinking or Cognition |  past € current |  |
| Hearing |  past € current |  | Communication |  past € current |  |
| Breathing |  past € current |  | Elimination |  past € current |  |
| Bone or Joint |  past € current |  | Pain |  past € current |  |
| Muscular |  past € current |  | Allergies |  past € current |  |
|  |  |  |
| Other |  past € current | *(please describe)* |

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

**PHYSICAL FUNCTION** (i.e. mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

**PSYCHO/SOCIAL FUNCTION** (i.e. work/school including grade completed, leisure interests, relationships family structure, support systems, companion animals, fears/concerns, etc.)

Signature Date

**Release and Hold Harmless Agreement**

IN ACCORDANCE WITH THE WASHINGTON STATE STATUTE, RCW.4.24.530:

The undersigned is aware that horse activities and riding involve many inherent dangers, risks and hazards; including, but not limited to, bodily injury and physical harm to the rider, groomer, leader, handler, photographer, spectator, helper and horse. I, the undersigned, freely and fully assume all such risks, dangers, and hazards and the possibility of personal injury, death, property damage or loss resulting from such risks, dangers and hazards. I, the undersigned, also assume above risks, dangers, hazards and possibilities for my minor child(ren) and wards in my care.

**I HEREBY AGREE AS FOLLOWS**

1. **TO ASSUME AND ACCEPT ALL RISKS, DANGERS AND HAZARDS** in connection with my use or my minor child(ren)’s and ward's use of the facilities.

2. **TO WAIVE ANY AND ALL CLAIMS**  that I may have against Healing Hearts Ranch, Jim Stillwater and Kristy Dees (property owners) and/or HeartStrides Therapeutic Program as a result of my use of and presence at the facility.

3. **TO RELEASE** Healing Hearts Ranch, Jim Stillwater and Kristy Dees, HeartStrides Therapeutic Program, the employees, volunteers, clients, property owners and all people present and/or involved with the property and horsemanship/riding programs, and/or other activities from any and all liability, rights of action or caused of action arising out of contract, tort or otherwise for any loss, damage, injury or expense that I, my minor child(ren), my next of kin, or my ward(s) may incur as a result of use of the facilities due to any cause whatsoever.

4. **THE UNDERSIGNED AGREES TO HOLD HARMLESS AND INDEMNIFY** Kristy Dees and Jim Stillwater and/or Healing Hearts Ranch/HeartStrides Therapeutic Program, and any employees, volunteers, agents, students, guests and spectators from any and all liability for personal injury, property damage or death suffered by myself, my child(ren) or by a third party as a result of my use and presence at the facility.

**5. THAT IN THE EVENT OF MY OR MY MINOR CHILD(REN)’S INJURY OR DEATH, OR OF THE INJURY AND DEATH OF MY WARD(S), THIS RELEASE AND INDEMNITY AGREEMENT** shall be effective and binding upon my heirs, next of kin, executors, administrators and assigns in relation to Healing Hearts Ranch, it’s property owners, HeartStrides Therapeutic Program, and any and all people involved.

 Please Initial

**I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTOOD THIS RELEASE AND INDEMNITY.** I am over 18 years of age, aware that by signing this document I am affecting the legal rights and liabilities of myself, my child(ren)/ward(s), my heirs, next of kin, executors, administrators and assigns in relation to Healing Hearts Ranch, its property owners, HeartStrides Therapeutic Program, and all people involved.

DATE NAME ***(please print)***

SIGNATURE ­

**I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTOOD THIS RELEASE AND INDEMNITY.** I am 18 years or older, HAVE THE AUTHORITY AS THE PARENT AND/OR GUARDIAN OF THE MINOR(S)

*(please print full name(s) of minor(s))*

TO SIGN AND RELEASE ON BEHALF OF THE MINOR(S), SO THAT THE MINOR(S) CAN PARTICIPATE AND USE THE FACILITIES OFFERED BY HEALING HEARTS RANCH. I am aware that by signing this document I am affecting the legal rights and liabilities of the minor(s), his or her heirs, next of kin, executors, administrators, and assigns in relation to Healing Hearts Ranch or HeartStrides Therapeutic Program, and all people involved with the property and facilities at 3500 85th Lane SW, Tumwater, Washington.

DATE NAME ***(please print)***

SIGNATURE ­­­­­

*Emergency names and phone contacts:*

Name Phone

Alternate Name Phone

**PHOTO RELEASE**

**⬜** I DO **⬜** DO NOT consent to and authorize the use and reproduction by HEALING HEARTS RANCH and HEARTSTRIDES 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.

DATE SIGNATURE *(client, parent or legal guardian)*

**Authorization for Emergency Medical Treatment Form**

Participant Staff Volunteer (please circle one)

Name DOB Phone

Address

Physician’s Name Preferred Medical Facility

Health Insurance Company Policy

Allergies to medication

Current medications

In the event of an emergency contact

Name Relation Phone

Name Relation Phone

Name Relation Phone

**Consent Plan**

In the event of emergency medical aid/treatment due to illness or injury during the process of receiving services or while being on the property of the program, I authorize Healing Hearts Ranch and/or HeartStrides Therapeutic Program to:

1. secure and retain medical treatment and transportation if needed and/or
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 “lifesaving” by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date Consent Signature

 *(client, parent or legal guardian)*

*Signed in presence of center staff*

**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.

1. Parent or legal guardian will remain on site at all times during equine assisted activities **OR**

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

Date Non-Consent Signature

 *(client, parent or legal guardian)*

*Signed in presence of center staff*

**Participant’s Consent for Release of Information**

I hereby authorize HEALING HEARTS RANCH or HEARTSTRIDES THERAPEUTIC PROGRAM to release information from the records of:

 DOB

 *(participant’s name)*

The information is to be released to: HEALING HEARTS RANCH or HEARTSTRIDES THERAPEUTIC PROGRAM, its OWNERS, EMPLOYEES OR INDEPENDANT CONTRACTORS, providing a service 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 (I.H.P.)
* Classroom Individual Education Plan (I.E.P.)
* Psychosocial evaluation, assessment and program plan
* Cognitive-behavioral management plan
* Other

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

Signature Date

Print Name Relation to Participant

Please send materials to:

 **HEARTSTRIDES THERAPEUTIC PROGRAM**

 **c/o Heather Daley**

 **PO Box 825**

 **Olympia, WA 98507**

*Note: These records are maintained with the utmost confidentiality and will not be available to anyone other than on a need-to-know basis with those working directly with the treatment team and instructor.*

Date

Dear Health Care Provider:

Your patient, ,

 *(participant’s name)*

is interested in participating in supervised equine activities.

To safely provide this service, our center requests that you complete/update the following Medical History and Physician’s Statement. Please note that the conditions listed may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Thank you very much for your assistance. If you have any questions or concerns regarding this patient’s participation in equine-assisted activities, please contact the center at the address/phone indicated above.

Sincerely,

Kristy Dees

Healing Hearts Ranch

HeartStrides Therapeutic Program

Attachment

**Medical History and Physician’s Statement**

**Orthopedic/Medical/Psychological**

|  |  |
| --- | --- |
| **Condition** | **Degree of Condition** |
| 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  |  |
| Danger to self or others |  |
| Pathologic fractures  |  |
| Exacerbations of medical conditions (i.e. RA, MS) |  |
| Spinal joint fusion/fixation  |  |
| Fire settings |  |
| Spinal joint instability/abnormalities  |  |
| Hemophilia |  |
| Recent Surgeries |  |
| Medical Instability |  |

**Neurologic**

|  |  |
| --- | --- |
| **Condition** | **Degree of Condition** |
| Chiari II Malformation |  |
| Migraines |  |
| Hydrocephalus/shunt PVD |  |
| Seizure  |  |
| Respiratory compromise |  |
| Tethered coed |  |
| Spina Bifida  |  |
| Hydromyelia |  |
| Substance Abuse |  |

**Other**

|  |  |
| --- | --- |
| **Condition** | **Degree of Condition** |
| Thought Control Disorders |  |
| Age - under 4 years Weight Control Disorder |  |
| Indwelling Catheters/Medical Equipment |  |
| Medications - i.e. Photosensitivity |  |
| Poor Endurance |  |
| Skin Breakdown |  |
| Other *(please describe)* |  |