



Legacy Equine

CENTER & SANCTUARY

Rider Registration Packet

Please fill out completely and return to:

Gerry Page, Board President

Legacy Equine Center and Sanctuary

gerrypagelegacy@gmail.com

Legacy Equine Center and Sanctuary
 26 Strong Street, Easthampton MA 01027
Phone: 413-495-2876
Email: gerrypagelegacy@gmail.com

Participant's Application & Health History

GENERAL INFORMATION

Participant: _____

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

Address: _____

Phone: _____ E-mail: _____ Alternative #: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone: _____

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, over-the-counter; name, dose and frequency) _____

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.)

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

Signature: _____ Date: _____

PHOTO RELEASE (check one)

I _____ DO _____ 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



Authorization for Emergency Medical Treatment Form

Name: _____ DOB: _____ Phone: _____

Address: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

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 property of the agency,

I authorize Legacy Equine Center and Sanctuary 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(s) above is unable to be reached.

Consent Signature: _____ Date: _____

Client, Parent or Legal Guardian

Liability Release

_____ (name) would like to participate in the Legacy Equine Center and Sanctuary program. I acknowledge the risks and potential risks of a horseback riding program. However, I feel that the benefits are greater than the risks assumed. I hereby, intending to be legally bound, waive and release forever all claims for damages against the Legacy Equine Center and Sanctuary, its Board of Directors, Executive Director, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses sustained while participating in the Legacy Equine Center and Sanctuary program.

Under Massachusetts law, an equine professional is not liable for injury to, or the death of, a participant in equine activities resulting from the inherent risk of equine activities pursuant to *Section 2D of Chapter 128* of the General Laws.

Signature: _____ Date: _____

Client, Parent or Legal Guardian



Participant's Consent for Release of Information

I hereby authorize: _____
(*person or facility*)

to release information from the records of: _____ DOB: _____
(*participant's name*)

The information is to be released to: _____
(*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 (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 can be revoked, in writing, at my request.

Signature: _____ Date: _____

Print Name: _____

Relation to Participant: _____

Please send materials to: _____

Please send materials to: _____



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 - i.e. Photosensitivity
- Poor Endurance

Medical/Psychological

- Allergies
- Animal Abuse
- Cardiac Condition
- Physical/Sexual/Emotional Abuse
- Blood Pressure Control
- Dangerous to Self or Others
- Exacerbations of Medical Conditions (i.e. RA, MS)
- Fire Settings
- Hemophilia
- Medical Instability
- Migraines
- PVD
- Respiratory Compromise
- Recent Surgeries
- Substance Abuse
- Thought Control Disorders
- Weight Control Disorder



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: AtlantoDens Interval X-rays, date: _____ Result: + —

Neurologic Symptoms of Atlanto Axial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

<i>Systems / Areas</i>	<i>Y</i>	<i>N</i>	<i>Comments</i>
<i>Auditory</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Visual</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Tactile Sensation</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Speech</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Cardiac</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Circulatory</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Integumentary / Skin</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Immunity</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Pulmonary</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Neurologic</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Muscular</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Balance</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Orthopedic</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Allergies</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Learning Disability</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Cognitive</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Emotional / Psychological</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Pain</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Other</i>	<input type="checkbox"/>	<input type="checkbox"/>	



Given the above diagnosis and medical information, this person is not medically precluded from participating in equine assisted activities and/or therapies. Therefore, I refer this person to the Legacy Equine Center and Sanctuary for ongoing evaluation to determine eligibility for participation.

PLEASE INITIAL ONE: I **DO** suggest an Adaptive Therapeutic Riding Program for this individual _____ or **DO** **NOT** feel that an Adaptive Therapeutic Riding Program is needed_____.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: () _____ License/UPIN Number: _____

