MONTGOMERY AREA NON-TRADITIONAL EQUESTRIANS

Participant Application

(Pages 1- 3, completed by the adult participant, participant's parent, or participant's legal representative, and 2additional pages, completed by physician, must be received before students can be considered for program participation. Paperwork is required to be updated each program year)

General Information

Participant's Name: _____

Date of Birth: _____ Height:_____ Weight:_____ Gender: M F

Address:_____

Home:_____ Cell: _____ Other:_____ Email:_____

Parent/ Legal Guardian Name(s) and Phone Number(s), if under age 18 or dependent adult:

_____

Emergency Contact (Name and Phone Number): _____

Employer/School (Name and Phone Number): _____

Health History

Diagnosis:_____ Date of Onset:_____

Please check all conditions that apply:

o Atlantoaxial Instability o Coxa Arthrosis o Heterotopic Ossification o Myositis Ossifcans o Osteoporosis o Neuromuscular Disorder/ MS/ Spinal Fusion/Fixation o Spinal Joint Instability o Spinal Curvature/ Scoliosis o Hydrocephalus o Shunt o Seizure o Spina Bifida	o Chiari II Malformation o Tethered Cord o Hydromyelia o Allergies o Animal Abuse o Cardiac Condition o Abuse o Blood Pressure Control o Dangerous to Self o Dangerous to Others o Fire Settings o Hemophilia o Medical Instability o Migraines o Pathological Fractures	o PVD o Respiratory Compromise o Recent Surgeries o Substance Abuse o Thought Control Disorders o Weight Control Disorders o Under 4 Years Old o Indwelling Catheters o Photosensitivity o Medication Precautions o Poor Endurance o Skin breakdown o Joint Replacement

Comments:_____

Allergies:_____

Medications:_____

MONTGOMERY AREA NON-TRADITIONAL EQUESTRIANS

MANE

Authorization For Emergency Medical Treatment

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 Montgomery Area Nontraditional Equestrians 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.

Consent Plan

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.

Consent: Yes:____ No:____

Signature:_____ Date:_____

Photography Consent/ Non-Consent

MANE (Montgomery Area Non-traditional Equestrians) often takes still pictures and/or videos of students, clients, volunteers and instructors. This is done for several reasons. Rider progress and acquisition of skills provide instructors and clients with necessary information and positive feedback. Photos/videos are also used in brochures, presentations, posters, and on our website for publicity. They are also occasionally provided to students for keepsakes.
Please check one of the boxes below to indicate your preference for photograph/video of you/your child for the aforementioned purposes.

Consent: Yes:_____ No:_____

Signature:_____ Date:_____

Confidentiality Agreement

I understand that all information (written and verbal) about participants at MANE is confidential and will not be shared with anyone without the expressed written consent of the participant and their parent/guardian in the case of a minor. This includes all medical, social, referral, personal, financial, and otherwise sensitive information. I understand that individuals who breach confidentiality will be removed from the MANE program.

Signature:_____ Date:_____

MONTGOMERY AREA NON-TRADITIONAL EQUESTRIANS

Release of Liability

To be completed by the adult participant, participant's parent, or participant's legal representative. This release of liability is made and entered into on this date, _____, by and between Montgomery Area Nontraditional Equestrians, hereinafter known as MANE, and staff/participant/volunteer (print name), _____, hereinafter known as participant, and (if a minor or incompetent adult) participant's parent, legal guardian, or legal representative (print name) _ _____. In return for participation in MANE's therapeutic horseback riding activities, special events and fundraisers, the participant, his/her heirs, assigns, and legal representatives hereby expressly agree to the following:

- Participant agrees to assume any and all risks involved in or arising from participant's participation or presence upon the property and facilities, including, without limitation, but not limited to the risks of death, bodily injury, property damage, falls, kicks, bites, collisions with vehicles, horses, or stationary objects, fire or explosion, the unavailability of emergency medical care, or the negligence or deliberate act of another person.

- Participant agrees to hold MANE and all of its successors, assigns, subsidiaries, franchisee, affiliates, officers, directors, employees, agents, and boarders completely harmless and not liable and release them from all liability whatsoever and agrees not to sue them on account of or in connection with any claims, causes of action, injuries, damages, costs or expenses arising out of participant's participation and/or presence upon MANE's property and facilities, including without limitation, those based on death, bodily injury, property damage, including consequential damages, except if the damages are caused by the direct willful and wanton negligence of MANE.

- Participant agrees to waive the protection afforded by any statue or law in any jurisdiction whose purpose, substance and/or effect is to provide that a general release shall not extend to claims, material, or otherwise, which the person giving the release does not know or suspect to exist at the time of executing the release.

- Participant agrees to indemnify and defend MANE against, and hold it harmless from, any and all claims, causes of action, damages, judgments, costs, or expenses, including attorney's fees, which in any way arise from participant's participation and/or presence upon MANE's property or facilities.

- This contract is non-assignable and non-transferable and is made and entered into the State of Alabama and shall be enforced and interpreted under the laws of this state. Should there be any clause in conflict with State Law, then that clause is null and void. When MANE and participant or participant's parent or legal guardian signs this contract, it will then be binding on both parties, subject to the above terms and conditions.

_____ Date: _____

Participant/ Parent/ Legal Guardian/ Legal Representative

_____ Date:_____

MANE Representative Signature

MONTGOMERY AREA NON-TRADITIONAL EQUESTRIANS

MANE

Physician's Statement

The patient listed below is interested in participating in supervised therapeutic horseback riding activities with the Montgomery Area Nontraditional Equestrians (MANE). In order to provide this service, our center requests that you complete the following medical history and release for riding.

Participant: _____DOB: _____ Height: _____ Weight: _____

Diagnosis: _____ Date of Onset: _____

Past Surgeries: _____

Prospective Surgeries: _____

Medications: _____

Please indicate any special precautions/ needs:

_____

_____

For Riders with Down Syndrome:

Prior to starting mounted activities, a medical examination with special reference to neurologic function must not reveal atlantoaxial instability or focal neurologic disorder. Additionally, participants must have an annual medical clearance from a licensed physician that includes a neurological exam that specifically denies any symptoms consistent with atlantoaxial instability.

- Negative for clinical symptoms of Atlantoaxial Instability Date of Examination:_____

Precautions and Contraindications

Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Please note whether these conditions are present and to what degree.

Orthopedic

•Atlantoaxial Instability	Y	N
•Coxa Arthrosis	Y	N
•Cranial Deficits	Y	N
•Heterotopic Ossification/Myositis Ossificans	Y	N
•Joint subluxation/dislocation	Y	N
•Osteoporosis	Y	N
•Pathologic Fractures	Y	N
•Spinal Joint Fusion/Fixation	Y	N
•Spinal Joint Instability/Abnormalities	Y	N

Neurologic

•Hydrocephalus/Shunt	Y	N	Date of Last Revision: _____
•Sensory Deficit	Y	N	
•Seizure	Y	N	Date of Last Seizure: _____
•Spina Bifida/Chiari II malformation	Y	N	
•Tethered Cord/Hydromyelia	Y	N	

Medical/Psychological

•Cardiac Condition	Y	N
•Physical/Sexual/Emotional Abuse	Y	N
•Blood Pressure Control	Y	N
•Exacerbations of medical conditions (i.e. RA, MS)	Y	N
•Hemophilia	Y	N
•Medical Instability	Y	N
•Migraines	Y	N
•PVD	Y	N
•Respiratory Compromise	Y	N
•Substance Abuse	Y	N
•Thought Control Disorders	Y	N
•Weight Control Disorder	Y	N

Recent Surgeries:

_____

_____

Allergies:

_____

_____

Medications:

_____

_____

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. 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: _____

Signature: _____ Date: _____

Address: _____ City _____ Zipcode _____

Phone: (_____) _____ License/UPIN Number: ____