EVALUATION Application Package

EQUINE THERAPY ASSOCIATES
www.equinetherapyassociates.com
P.O. Box 59253 ■ Potomac, MD ■ 20859-9253 ■ USA
Phone: 301.972.7833 Fax: 301.972.7101
Emergency Phone: 301.651.6622

Thank you for registering for a two hour Evaluation at Equine Therapy Associates!
You will view our entire facility, including our three rings, our four barns, our Tack Room, Feed Room, Reception Area, and our new Therapy Suite (classroom, exercise room, and offices). You will also meet our ponies and our Director, Dr. Hansen. You may also meet one of our other three instructors.

Mostly importantly, you and your family member will have a stimulating and educational experience, with no "testing" stress. You and the student will be fitted with a helmet and body protector, you will groom and tack a pony, if appropriate, and he/she may lead or ride a pony, if this can be done safely. Your family will be able to try a variety of apparatus (push/pull toys, a mini tramp, various OT/PT aides, exercise balls), many ring games and toys, be fitted for a saddle on our artificial horse "Hans," and experience a Sensory Integration box or trail. Your family member will try many of our basic exercises for strength-building and enhancing balance and flexibility, while you will examine our 17 basic take-home cognitive enrichment books, and be introduced to the hundreds of take-home lender books on ponies, cats and other animals, along with our basic safety oriented curriculum. **At the end of the Evaluation, or within a short time, you will receive a written two page Evaluation on 40+ key elements that will help all of us decide if ETA can safely offer your family NARHA approved equine activities!**

1. **ETA is unable to process incomplete forms:** The entire application package, including a ***check for $150.00,*** should arrive SEVERAL DAYS BEFORE THE SCHEDULED EVALUATION, as ETA needs time to design an appropriate Lesson Plan. Please call to confirm that your package has arrived, and driving directions will be emailed as soon as your application package is complete.

2. **Student Forms**: Please print out each of the ***four*** NARHA-required forms in the Evaluation Package on the Registration button at our website, www.equinetherapyassociates.com, and return them to ETA at P.O. Box 59253, Potomac, MD 20859. Congratulations! ***You are now covered by ETA's insurance!***

3. **Parent/Guardian/Care-Giver Forms:** Any adult who will attend the Evaluation must fill out his/her **four** NARHA-required forms completely and return them *in the student package.* (You do not need a tetanus shot current within five years, or a negative TB test current within 12 months just for the Evaluation; both are required if you will be with the rider in lessons as a sidewalker. The student will also need a current tetanus shot if he/she enrolls for lessons.) Congratulations! ***You are covered by ETA's insurance!***

4. ***If you choose to enroll your family member for lessons***, you will only need to fill out two more forms (#5 and #6) for the physician's assessment) in the New Student Package.

"ETA needs from EVERY potential rider, volunteer and or apprentice the "Participant's Consent for Release of Information." Without it, ETA is unable to comply with federal regulations requiring proof of your consent to hold any confidential data. If you will **not** be a rider, check "Other: Personal, contact, emergency medical, hospital and insurance data."

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NARHA
North American Riding for the Handicapped Association, Inc.
PREMIER ACCREDITED CENTER

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: Equine Therapy Associates

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
- ❑ Occupational 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:

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To be completed by the participant or parent/legal guardian.

Participant's Application and Health History (Page 1 of 2)

GENERAL INFORMATION

Participant: _____

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

Address: _____

Phone: _____ E-mail _____ Alternative #: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian/Caregivers: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

Phone: _____

How did you hear about the program? _____

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			
Infectious Diseases/ Colonized Conditions			

Participant's Application and Health History (Page 2 of 2)

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

I ❑ DO
❑ DO NOT
consent to and authorize the use and reproduction by ***Equine Therapy Associates***
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
Signed in the presence of center staff

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Authorization for Emergency Medical Treatment Form

❑ Participant ❑ Staff ❑ Volunteer

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current medications: _____

Date of last tetanus shot: _____; Date of last TB test: _____; Are you positive for any infectious disease or are you "colonized" for any antibiotic resistant bacterium/fungus? _____, if so what: _____. If so, what precautions must you and ETA's staff and volunteers take to prevent contamination? _____.

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 _____Equine Therapy Associates_____ 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.

Date: _____ Consent Signature: _____
Client, Parent or Legal Guardian
Signed in presence of ETA 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

❑ 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 procedure to take place:

_____

_____

_____

Date: _____ Non-Consent Signature: _____
Client, Parent or Legal Guardian
Signed in presence of ETA staff

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Print Name: _____

Relation to Participant: _____ _____

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Volunteer/Staff Information Form and Health History

General information

Name: _____ Date: _____

Address: _____

Date of Birth: _____ Phone: (H)_____ (W)_____

Employer/School: _____

Address: _____

Parent/Legal Guardian/Caregiver Name/Address/Phone Number:_____

_____

How did you learn about the program? _____

Recent medical tests: Last Tetanus Shot: _____ Tuberculosis Test + -- Date: _____

(Consult your physician or local health department if you are not up to date with these shots/tests)

Health History

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries, or lifestyle changes.

_____

_____

_____

_____

_____

_____

_____

Allergies: _____

_____

Medications: _____

_____

_____

Check which areas you are interested in:

Program	Special Events	Administration	
❑ Horse Handling	❑ Horse Show	❑ Public Relations	❑ Photography/Video
❑ Sidewalking with a Student	❑ Fundraising	❑ Grant Writing	❑ Budget & Finance
❑ Stable Management	❑ Special Olympics	❑ Newsletter	❑ Future Planning
❑ Facility Repairs	❑ Trail Rides	❑ Volunteer Recruitment	

I understand that the information provided above is accurate to the best of my knowledge. I know of no reason why I should not participate in this center's program.

Signature: _____ Date: _____

(volunteer/staff/caregiver; signed in presence of center staff)

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Volunteer/Staff Information Form and Health History -

Page 2

Name: _____

Address: _____

Phone: _____ Date of Birth: _____

Photo Release

I ❑ DO
❑ DO NOT

consent to and authorize the use and reproduction by Equine Therapy Associates 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 center

Signature: _____ Date: _____

Background Information

Have you ever been charged with or convicted of a crime? Y N; please explain _____

_____

_____

I, _____ (volunteer/staff), authorize Equine Therapy Associates to receive information from any law enforcement agency including police departments and sheriff's departments, of this state or any other state or federal government, to the extent permitted by state and federal law, pertaining to any convictions I may have had for violations of state or federal criminal laws, including but not limited to convictions for crimes committed upon children or animals.

I understand that such access is for the purpose of considering my application as an employee/volunteer, and that I expressly DO NOT authorize the NARHA center, its directors, officers, employees, or other volunteers to disseminate this information in any way to any other individual, group, agency, organization, or corporation.

Signature: _____ Date: _____
(volunteer/staff)

CURRENT DRIVER'S LICENSE Y N LICENSE NUMBER _____ STATE _____

Confidentiality Agreement

I understand that all information (written and verbal) about participants at this NARHA center 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

Signature: _____ Date: _____
(volunteer/staff)