NEW STUDENT Forms 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 applying to ETA!

1. **Please note that NO ONE WHO IS NOT TO BE AN ETA VOLUNTEER SHOULD ATTEND THE FARM VOLUNTEER TRAINING! For safety reasons, children who will be taking lessons should be left at home, cared for by family members or sitters. Thank you!**

2. **ETA is unable to process incomplete forms**. Please send the first four forms (below) to ETA's P.O. Box at least a week before your first lesson is scheduled. A check for your full tuition should be included, along with the complete Volunteer Package for the family member who will be accompanying your rider. Please send forms five and six to your physician; they will be mailed back to ETA separately. Please note that it is ESSENTIAL that ALL parents, except parents of fully ambulatory, adult, independent riders, complete and mail back to ETA the Volunteer/Apprentice Application Package, as these parents will be working closely with their children in lessons, and need to be fully trained. Thank you!

3. All forms should be signed, except where it asks you to do so in the presence of a staff member. You will do that at the first training session.

4. If you are applying for a scholarship, please contact the Director at (301) 972-7833, and request an ETA scholarship application form. Return the form as soon as possible, along with a processing fee of $35.00.

5. Please note that the physician's office should mail back forms (#5 and #6) to ETA at P.O. Box 59253, Potomac , MD 20859.

6. Parent Volunteers MUST complete the PATH int'l online training, and ETA's Farm Volunteer Training, before lessons begin. Go to ETA's website, click on the Annual Calendar, investigate your Farm Volunteer Training options, and then call the ETA office at (301) 972-7833 or (301) 651-6622 to register for a Farm Volunteer Training session that is scheduled ***before*** the date that your child will begin lessons. Please also note that we are not able to train parent volunteers until payment is received for their child's lessons. Your online volunteer training course from PATH int'l must also be completed before your child begins his/her lessons, and ETA must receive the Course Completion Certificate before your child begins lessons. Follow the directions on the Volunteer/Apprentice Package to take this course. Thank you.

Please include with your application package written documentation from your physician or clinic that you have received a tetanus shot (current within five years) and a NEGATIVE TB test (current within 12 months). Thank you!

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.

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

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: Personal, telephone, email, medical, medicine, and insurance numbers/hospital preference information on parent and or rider forms

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:

Equine Therapy Associates
P.O. Box 59253
Potomac, MD 20859-9253

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

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 _____
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

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

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

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

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
Coxa Arthrosis
Cranial Deficits
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 Cord/Hydromyelia

Other
Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

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

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

Sincerely,

Carol Rae Hansen, Ph.D.

Director, Equine Therapy Associates

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

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 AtlantoAxial Instability: _____

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

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Infectious Diseases/ Colonized Conditions			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the PATH int'l center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH int'l center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: ( )_____ License/UPIN Number: _____