PARTICIPANT INFORMATION FORM

THE HORSES FOR HANDICAPPED FOUNDATION OF PINELLAS
COUNTY, INC.
P.O. Box 3748, Seminole, Fl 33775-3748
www.pinellashforh.org

Greetings from the Horses for Handicapped riding program. The following information will help us determine how we can best help you or your child and bring to our attention any necessary precautions we should be aware of for safety reasons.

Please complete the **entire** form, have your physician complete and sign the **Medical History and Physician Statement section** and return the complete package to us.

PARTICIPANT INFORMATION

Participant's Name: _____ Date of Birth: _____

Parent/Legal Guardian: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address (**Please** print clearly): _____

Emergency Phone/Contact Name (& relationship):

1. _____

2. _____

Alternate Phone/Contact Name (& relationship):

1. _____

2. _____

Please respond to the following:

1. Does the participant have any fears we should know about (falling, animals, height, etc)?

2. Has the participant had any previous experience with horses?

3. Are there any triggers we should be aware of in order to prevent or be aware of a specific response based on participant's condition (physical or behavioral)?

4. Has the participant had any seizures in the last 6 months? If so, please explain.

5. Are there any other specific problems we should be aware of or other comments you would like to add (in your own words – please note that medical information is later in this package)?

Medications:

List all medications that might affect the participant's ability to ride or be in the outdoors.

Additional Information continued from prior pages (changes since last report, surgeries, etc.)

COMPLETED/SIGNED FORMS MUST BE RETURNED TO THE ADDRESS BELOW BY THE REQUESTED DUE DATE

PHOTO RELEASE

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to THE HORSES FOR HANDICAPPED permission to take or have taken, still and/or moving photographs and films including television picture of the undersigned and consents and authorizes THE HORSES FOR HANDICAPPED, its advertising agencies, news media, and other persons interested in THE HORSES FOR HANDICAPPED and its work, to use and reproduce the photographs, films and pictures to circulate and publicize the same by all means, including but not limited to newspapers, television media, websites, brochures, pamphlets, instructional materials, books and clinical material.

With regard to the foregoing material, no inducements or promises have been made to the undersigned to secure my signature to this release other than the intention of THE HORSES FOR HANDICAPPED to use or be used such photographs, films and pictures for the primary purpose of promoting and aiding THE HORSES FOR HANDICAPPED and its work.

Agree to Release: ☐ Yes _____ ☐ No _____
initial *initial*

UPDATES/DISCLOSURES

Parent or legal guardian agrees to update the Riding Director (Mary Urquhart) with any changes in medical or emotional condition in between annual updates of this document, especially upon return from holidays or the long summer break. In addition any medications, surgeries, or medical procedures completed that may affect the participants ability to ride must be disclosed and discussed prior to mounting a horse.

The HORSES FOR HANDICAPPED is a volunteer run program and as such, parents and legal guardians are encouraged to assist with side walking and other volunteer tasks (appropriate dress required – i.e. closed toe shoes around the horses). **Parent/legal guardian acknowledges and agrees that they will be present during the riding sessions.** If unable to be present, it is the parent's obligation to provide advance notification and obtain prior approval of the Riding Director of the replacement "guardian" that will be standing in for them. The participant must be dressed appropriately, wearing closed toe shoes and long pants.

The riding director and instructors will determine if participants can participate safely in the riding program initially and on a week-to-week basis. Should the instructors assess any contraindications regarding the participant and their participation in the riding program, it is up to the discretion of the instructors to either allow or remove the participant from the riding program.

I have reviewed the information herein and certify it is current and accurate. Furthermore, I agree to and have completed/signed the "Parent-Legal Guardian Release Agreement".

Name (Parent/Legal Guardian): _____
print clearly

Signature: _____ Date: _____

PLEASE CONTINUE ON TO MEDICAL SECTION

PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT
(Physician Evaluation/Signature required every 3 years)

MEDICAL INFORMATION

Participant's Name: _____ Date of Birth: _____

Height: _____ Weight _____

Parent/Legal Guardian: _____

Diagnosis: _____

Brief medical History, including surgeries: (continue on next page)_____

_____

_____

PLEASE indicate if patient has (or has had) a problem and/or surgeries in any of the following areas. CHECK ALL THAT APPLY (Any "YES" response requires comments/explanation)

CONDITION	YES	NO	COMMENTS/EXPLANATION
Allergies			
Auditory			
Autism Spectrum			
Blood Disorders			
Cardiac			
Cancer			
Circulatory			
Coordination/ Balance Challenges			
Diabetes			
Incontinence			
Learning Disabilities			
Mental Impairment			
Muscular			
Neurological *(seizures, other)*			
Orthopedic			
Poor Endurance			
Psychological			
Pulmonary			
Speech			
Visual			
Other			
Down Syndrome (see release) **ATLANTOAXIAL DISLOCATION** *Down Syndrome - participants must have a physicians release based on neck x-rays before participation.*			Release on file: ☐ Yes ☐ No Date of Release: _____

Mobility: Independent Ambulation: ☐ Yes ☐ No Crutches: ☐ Yes ☐ No Braces: ☐ Yes ☐ No

Wheelchair: ☐ Yes ☐ No

The following conditions, if present, may represent precautions or contraindications to recreational and/or therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, to what degree, and whether limitations are imposed by the condition. Please circle and comment regarding applicable conditions.

CONDITIONS	COMMENTS	CONDITIONS	COMMENTS
NEUROLOGIC		**ORTHOPEDIC**	
Chiari II Malformation		Atlanto-Axial Instabilities	
Hydrocephalus/shunt		Coxas Arthrosis	
Hydromyelia		Cranial Defects	
Paralysis due to spinal cord injury		Heterotopic Ossification	
Seizure Disorders		Hip Subluxation/Dislocation	
Spina Bifida		Internal Spinal Stabilization Devices	
Tethered Cord		Kyphosis	
Cerebral Palsy		Lordosis	
MEDICAL/SURGICAL		Osteoporosis	
Allergies		Pathologic fractures	
Asthma		Scoliosis (please select grade- mild, moderate, severe)	
Arthritis		Spinal Fusion	
Cancer		Spinal Instabilities/Abnormalities	
Diabetes		Spinal Orthosis	
Hemophilia		Joint Replacement	
HIV/Aids		**SECONDARY CONCERNS**	
Hypertension		Acute Exacerbation of Chronic Disorders	
Peripheral Vascular Disease		Agoraphobia	
Poor endurance		Behavior problems	
Poor head and neck control		Panic disorders	
Serious Heart Condition		Sensory deficits	
Stroke		Weight Exceeds 200 lbs.	
Varicose Veins			

I HEREBY CERTIFY THAT THE ABOVE PARTICIPANT HAS BEEN EXAMINED AND FOUND PHYSICALLY ABLE TO TAKE PART IN THE HORSES FOR HANDICAPPED PROGRAM.

Exceptions (list): _____

_____

Precautions: _____

_____

Physician's Name (Print, Stamp, Type)	Physician's Signature (Do not stamp)	Date Signed
	_____ MD ☐ DO ☐	Phone

COMPLETED/SIGNED FORMS MUST BE RETURNED TO THE ADDRESS BELOW BY THE REQUESTED DUE DATE.

Date of last Physician's Signature _____. I affirm that all information on this health record form is still current and correct, on this _____ day of _____20_____.

_____

(Parent/Guardian Signature)