

# Horse and Buddy Rider Information

4728 Old US 1 Hwy  
New Hill, NC 27562

(919) 367-7740  
Email:Holly@horseandbuddy.org

Rider's name: \_\_\_\_\_

Pronoun (He/Him, She/Her, They/Them):\_\_\_\_\_

Email: \_\_\_\_\_ Phone number:\_\_\_\_\_

Home address: \_\_\_\_\_

DOB: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Parent/Guardian names/phone #: \_\_\_\_\_

Parent/Guardian place of employment: \_\_\_\_\_

Emergency Contact:\_\_\_\_\_

Precautions:\_\_\_\_\_

Current medications: \_\_\_\_\_

Current school: \_\_\_\_\_

Physician name: \_\_\_\_\_ Phone number: \_\_\_\_\_

What therapies does rider currently participate in: OT, PT, SP, Mental health, ABA,  
Other:\_\_\_\_\_

Are there any therapy goals that you would like to share with us:

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What are you and/or your rider's goals for their participation in Equine Assisted Services?

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Is there any other information that you feel would help us to work with you or your child (i.e. behavior issues, favorite songs or activities, fears, etc.)?

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# Horse and Buddy Liability Release

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Email:Holly@horseandbuddy.org

**READ CAREFULLY BEFORE SIGNING.  
THIS IS A BINDING CONTRACT THAT AFFECTS YOUR LEGAL RIGHTS.**

**Horse and Buddy  
4728 Old US 1 Hwy  
New Hill, NC 27562  
(919) 367-7740**

I recognize that participation in the activities in the Horse and Buddy program located at 4728 Old US 1 Hwy, New Hill, NC (“the facility”) involves significant hazards and risks in riding and handling horses. I certify that neither I nor the participant for which I am responsible has any physical conditions which might interfere with my/his/her capacity to participate in horseback riding and other activities offered by the Horse and Buddy program. Knowing the inherent risks, dangers and rigors involved in horseback riding and other activities involving horses, I assume full responsibility for myself or the participant for which I am responsible for any and all bodily injury, death, loss of personal property and expenses thereof, which may occur as a result of participation in the handling of horses, horseback riding and other activities sponsored by the Horse and Buddy program or may occur at the facility. I waive any and all claims which may result from any such participation. I expressly release and waive all such liability and claims, even if they should arise out of the negligence of other persons, including other persons released hereby. I further agree that if anyone makes any claim on my behalf or on behalf of the participant for which I am responsible because of any injury, death or damage to property, I will indemnify and hold harmless all of those persons released by this agreement against any damage, or costs which may result because of those claims, including legal fees.

I will observe all rules, regulations and instructions of the facility and will exercise due care to avoid injury, damage or loss to person and property. I certify that I have received a copy of the current rules and policy and understand that any infractions of the rules may terminate any business I have with the program or right to participate in the program.

The persons and entities which are hereby released and to which the benefit of this liability and release adheres are Horse and Buddy, Inc. and its employees, volunteers, participants, guardians, officers, directors and any other person connected to or participating in the Horse and Buddy program.

I have read, understand and agree to the terms and conditions stated herein. I acknowledge that this agreement shall be effective and binding upon me and the participant for whom I am responsible during the entire period of my/his/her participation in the handling of horses and/or the participation and therapeutic riding lessons upon the premises of the facility.

**The undersigned understands that under North Carolina Law an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting exclusively from the inherent risks of equine activities. Chapter 99E of the North Carolina General Statutes.**

Signature of participant or parent/guardian if under 18.

This \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_ Participant

\_\_\_\_\_ Print name

\_\_\_\_\_ Parent/Guardian witness

# Horse and Buddy Participant Photo/Video Release

Please sign **only one** option:

**1. Consent Plan**

I consent to and authorize the use and reproduction by Horse and Buddy of any and all photographs and any other audio/visual materials, including videotape taken for promotional material, educational activities, exhibitions, social media or for any other use for the benefit of the program.

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Consent Signature:** \_\_\_\_\_

**2. Internal Consent Plan**

I consent to and authorize the use and reproduction by Horse and Buddy of any and all photographs and any other audio/visual materials, including videotape taken for **internal use only**. This includes photographs in the barn only or video and photographs for staff and volunteer education only. This does not include the use of photographs or videos that are shared on social media or in the public for promotional material or exhibitions.

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Consent Signature:** \_\_\_\_\_

**3. Non-Consent Plan**

I do not give my consent nor do I authorize the use and reproduction by Horse and Buddy of any photographs or any other audio/visual materials.

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Consent Signature:** \_\_\_\_\_

# Horse and Buddy Confidentiality Policy

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Email:Holly@horseandbuddy.org

Because of the nature of the program, Horse and Buddy may have access to confidential medical and financial records of participants. To protect the confidentiality of our participants, Horse and Buddy has instituted a confidentiality policy. Horse and Buddy shall preserve the right of confidentiality for all participants in its program. Individuals bound by this policy include part and full time staff members, volunteers who may have access to confidential knowledge, independent contractors involved with the program, instructors and board members. Individuals subject to this policy shall keep confidential any and all medical, social, referral, personal, and financial information regarding a person and/or his or her family. All participants or participant's parent(s), legal representatives, or others as defined by state statute must sign consent or non-consent release forms regarding medical and sensitive information disclosure, and consent or non-consent release forms regarding use of photography and/or videotape prior to participation in the program. Penalties for breach of confidentiality shall include the immediate loss of any responsibilities that would allow the individual access to confidential records. Additional penalties may include, at the discretion of the board of directors, reprimand, loss of certain job responsibilities, and/or termination from the program.

*I understand and will observe the confidentiality policy of Horse and Buddy.*

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Consent Signature:** \_\_\_\_\_

I understand that the medical, financial, social, referral, and personal information about me/my son/my daughter or my ward that Horse and Buddy may have on record will be kept confidential as outlined in the confidentiality policy above. However, I hereby consent to and authorize the disclosure by Horse and Buddy to its volunteers any medical information that Horse and Buddy believes is necessary for volunteers to know for the safety of the participant and/or the volunteer.

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Consent Signature:** \_\_\_\_\_

# Horse and Buddy

4728 Old US 1 Hwy  
New Hill, NC 27562

## Medical History & Physician Statement

(919) 367-7740  
Email: Holly@horseandbuddy.org

Date: \_\_\_\_\_

Dear Healthcare 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 indication above.

Sincerely,

Janet Mason  
Executive Director

# Horse and Buddy

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## Medical History & Physician Statement

(919) 367-7740  
Email: Holly@horseandbuddy.org

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_  
 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: \_\_\_\_\_  
 Spinal fusion or rod: Y N Date of procedure: \_\_\_\_\_  
 Special Precautions/Needs: \_\_\_\_\_

Mobility: Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N  
 Braces/Assistive Devices: \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Dr. Initials:** \_\_\_\_\_

**Please indicate current of 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			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH 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: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_