

Horse and Buddy Therapeutic Riding Program

4728 Old US 1 Hwy
New Hill, NC 27562

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

Please fill out the following information to assist us in serving you or your child while they are enrolled in the Horse and Buddy Therapeutic Riding Program. If any information is not applicable, simply answer N/A. You may also attach a copy of the therapist's goals.

Rider's name : _____ Phone number: _____

Email: _____ Home phone number: _____

Home address: _____

DOB: _____ Diagnosis: _____

Parent/Guardian names/phone #: _____

Parent/Guardian place of employment: _____

Precautions:

Current medications: _____

Current school: _____

Physician name: _____

Phone number: _____

Physical Therapist name: _____

Phone number: _____

Current PT goals:

Occupational Therapist name: _____

Phone number: _____

Current OT goals:

Speech Therapist name: _____

Phone number: _____

Current Speech goals:

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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Confidentiality Policy

Because of the nature of the program, Horse and Buddy Therapeutic Riding Program may have access to confidential medical and financial records of riders. To protect the confidentiality of our riders, Horse and Buddy has instituted a confidentiality policy. Horse and Buddy Therapeutic Riding Program shall preserve the right of confidentiality for all riders participating 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 riders or rider 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: ___/___/____ 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 rider and/or the volunteer.

Date: ___/___/____ Signature: _____

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

**Horse and Buddy
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LIABILITY RELEASE

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

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Please sign one or the other:

**Rider Photo/Video Release
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 of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Date: ___/___/____ Consent Signature: _____

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 taken of me.

Date: ___/___/____ Non-Consent Signature: _____

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Participant's Medical History & Physician's Statement

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

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Participant's Medical History & Physician's Statement

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: _____
 Special Precautions/Needs: _____

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

We must have a documented height/weight to match our riders to an appropriate horse.

Height: _____ **Weight:** _____ **Dr. Initials:** _____

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			
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: _____