Participant Sign-up Package

Therapeutic Horsemanship of Hawaii
PO Box 138
Waimanalo, HI 96795
(808) 342-9036
dana@thhwaimanalo.org
www.thhwaimanalo.org

Participant's Application & Health History

GENERAL INFORMATION

Participant:_____

DOB: _____Age: _____Height: _____Weight: _____Gender: M F

Address: _____

Phone: _____Alternative #: _____

Email: _____

Parent/Legal Guardian (if participant under 18): _____

Address (if different from above): _____

Phone (if different from above): _____

Caregivers (if different from above): _____

Referral Source/phone (if applicable): _____

How did you hear about the program (circle)? Internet search Link to THH website on _____

Hawaii Parent Magazine *Hawaii Military Guide* Search on PATH Intl Website

Friend or acquaintance Presentation/booth at _____

Other:_____

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			

MEDICATIONS (include prescription and over-the-counter; name, dose and frequency) _____

Describe your abilities/difficulties in the following areas (include assistance or equipment required):

PHYSICAL FUNCTION (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding) _

PSYCHO/SOCIAL FUNCTION (e.g.,. work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

GOALS (i.e. why would you like to participate? What would you like to accomplish?_____

I certify the above information is correct to the best of my knowledge

Signature: _____Date: _____
Client (or Parent or Legal Guardian if client is under 18)

PHOTO RELEASE

I ❑ DO
❑ DO NOT
consent to and authorize the use and reproduction by Therapeutic Horsemanship of Hawaii of any and all photographs, videos 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 (or Parent or Legal Guardian if client is under 18)

CONFIDENTIALITY POLICY

I understand that any personal or identifying information that I learn about clients through my association with Therapeutic Horsemanship of Hawaii, Inc. will remain confidential. I agree to refrain from discussing such details as: clients' names, specific diagnosis, unusual behavior, etc., with anyone outside the program or with another program member in a public circumstance where I might be overheard. I understand the necessity of preserving our clients' privacy and anonymity and will abide by this agreement.

Signature: _____Date: _____
Client (or Parent or Legal Guardian if client is under 18)

RELEASE AGREEMENT

THERAPEUTIC HORSEMANSHIP of HAWAII, INC.

AND CONTRIBUTORS

I, the undersigned, understand that Hawaii Law (Hawaii Revised Statutes Chapter 663B) limits the civil liability of persons sponsoring equine activities. I understand that there are inherent risks of injury, including death, when participating in an equine activity, which risks include but are not limited to (1) the propensity of an equine to behave in ways that may result in injury or death to persons on or around them, (2) the predictability of an equine's reaction to such things as sounds, sudden movement and unfamiliar objects, persons or object animals, (3) hazards such as surface and sub-surface conditions, (4) collisions with other equine or objects, and (5) the potential negligence of another participant, such as failing to maintain control over the equine, or not acting within the participant's ability. Knowing and understanding the risks of participating in an equine activity; including injury and death to my person and damage to my personal property, I expressly choose to assume these risks. Further, on behalf of myself, my heirs, successors, representative, and assigns, I hereby unconditionally release any and all claims and causes of actions against equine activity sponsor Therapeutic Horsemanship of Hawaii and the Honolulu Polo Club, and its/their owners, landlords, shareholders, officers, directors, principals, employees, agents, representatives and any other personnel, for injury including death, and for any damage to personal property, which I may incur as a result of my participation in this equine activity. I, the undersigned, agree to indemnify the above-described equine activity sponsor (including its/their above-described persons and entities) from any and all claims and causes of action brought by or on behalf of said participant at any time.

Date:_____

Rider printed name:_____

Is rider under 18 years of age? ☐ Yes ☐ No

IF RIDER IS UNDER 18 YEARS OF AGE A PARENT OR GUARDIAN MUST SIGN BELOW

Rider or parent/guardian SIGNATURE:_____

Parent/guardian printed name (if rider is under 18):_____

THH Billing Information Sheet

Student(s) (first and last name(s))	
Bill to (full name)	
Street Address	
City, State, Zip	
Phone	
Email* (please print clearly)	

Cancellation Policy

Horses are very expensive to maintain, and we depend on income from our lessons to keep the program going! In order to effectively manage paid staff and volunteer hours, THH must enforce the following cancellation policy:

- Cancellations made less than 24 prior to the lesson start time will be billed for the full rate of the lesson
    - There are exceptions to this policy on an individual basis for sudden illness or emergencies. Please call as soon as practical in these cases.
    - There is no charge when THH cancels lessons due to weather or other conditions.
- We often have a waiting list, and if we have advance notice we can schedule other riders in place of canceled lessons.
- If you miss three lessons in a row, we reserve the right to schedule someone else at that time.

Thank you for your cooperation!

I understand that I will be billed for any services provided to the above student(s), and I agree to pay for these services.

(signature)

*Providing an email address allows THH to send you statements electronically. Your email address will be used solely to facilitate electronic billing and communications with THH. You will be able to view and pay your statements online by credit card at the website indicated on the statement. You will also be able to pay by mailing a check or providing cash/check to THH staff. THH is offering the option of billing as a convenience to its clients.

Please review the medical conditions listed on the next page. If any of the listed conditions is present for the participant, a physician's statement will be required prior to participation in equine activities. To obtain a physician's statement, complete and provide this form with the attached *Information Supporting Medical Screening of Participants* and *Medical History & Physician's Statement* to the participant's medical provider. Please contact our staff at (808) 342-9036 if you have any questions related to a condition or the screening process.

Participant's Consent for Release of Medical Information

I hereby authorize: _____
(medical provider or facility)

to release information from the records of: _____DOB: _____
(participant's name)

The information is to be released to: Therapeutic Horsemanship of Hawaii
(center name)

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
- ❑ 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: Therapeutic Horsemanship of Hawaii
PO Box 138
Waimanalo, HI 96795

808-342-9036

Information Supporting Medical Screening of Program Participants

Dear Health Care Provider:

Your patient _____

(participant's name)

is interested in participating in supervised equine activities at Therapeutic Horsemanship of Hawaii.

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
Coxarthrosis
Cranial Defects
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 Coed/Hydromyelia

Other

Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - e.g., 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 (e.g., 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.

Sincerely,

Dana Vennen, Executive Director
Therapeutic Horsemanship of Hawaii
PO Box 138
Waimanalo, HI 96795
(808) 342-9036

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: Neurologic Symptoms of Atlantoaxial Instability: _____ Present _____ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

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

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

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: (___) _____ License/UPIN Number: _____