PARTICIPANT'S APPLICATION & HEALTH HISTORY

Form must be completed in its entirety.
Forms without signatures/dates will be returned

GENERAL INFORMATION

Participant's Full Name:_____

DOB: _____ Age: _____Height:_____Weight:_____ lbs Gender: M F
Address: _____

_____

City:_____ State: _____ Zip: _____

Home Phone: _____ Work Phone:_____
Cell Phone: _____ E-mail address:_____

Employer/ School: _____

Parent/ Legal Guardian/Caregiver: _____
Relationship to Rider: Parent Guardian ☐ Caregiver ☐

Address (if different from above):

_____

_____

Home Phone:_____ Work Phone:_____
Cell Phone:_____ Email Address: _____
Referral Source/ How did you hear about the program: _____

MEDICAL INFORMATION

Diagnosis:_____
Date of Diagnosis:_____Allergies:_____

Seizures: Yes No If yes, date of last seizure:_____

Medications: _____
Physician's Name: _____
Preferred Medical Facility: _____
Health Insurance Company: _____ Policy #_____

In Case of Emergency:
Contact Name:_____ Relationship:_____ Phone:_____
Contact Name:_____ Relationship:_____ Phone:_____

Medical Release:

In the event emergency medical aid/treatment is required due to illness or injury while present on the property of Whispering Manes, (check one) [☐ I authorize] [☐ I do not authorize] Whispering Manes Therapeutic Riding Center to secure transportation and medical treatment including x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital service rendered under the general or specific instructions of any physician or hospital. The undersigned hereby agrees to pay all fees and expenses of doctors, hospitals, ambulances and other medical expenses reasonably and necessarily incurred.

I understand that the information provided above is accurate to the best of my knowledge. I know of no reason why I should not participate in this center's program.

I HAVE READ AND MADE A SELECTION FOR EMERGENCY MEDICAL AS INDICATED ABOVE:

Signature (Parent or Guardian if minor):_____
Printed Name: _____ Date:_____

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Describe the participant's abilities/ difficulties in PHYSICAL FUNCTION (include assistance required or equipment needed):
(eg. mobility skills such as transfers, walking, wheelchairs, braces, driving or car riding)

_____
_____
_____
_____

GOALS (Why are you applying for participation? What would you like to accomplish?)

_____
_____
_____
_____
_____
_____
_____

PHOTO RELEASE
I DO ☐ DO NOT ☐
consent to and authorize the use and reproduction by Whispering Manes Therapeutic Riding Center 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:_____
(Participant/Parent/ Legal Guardian)

PRIVACY STATEMENT
We are required by law to maintain the privacy of, and provide individuals with, this notice of legal duties and privacy practices with respect to your protected health information. If you have any objections to this form, please ask to speak with the Executive Director, in person or by phone.

I acknowledge that I have received Whispering Manes Therapeutic Riding Center's privacy policy.

Signature: _____ Date:_____
(Participant/Parent/Legal Guardian)

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out the formulation of a riding program and /or participation at Whispering Manes Therapeutic Riding Center (WMTRC), and/or for payment and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved with you for the purpose of your participation at WMTRC and any other use required by law .

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your participation at Whispering Manes and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a staff member or volunteer to assist them in helping you.

Payment

Your protected health information may be used, as needed, to obtain payment for your services.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures

Will be made only with your consent, authorization or opportunity to object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that WMTRC has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

WMTRC is not required to agree to a restriction that you may request. If they believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another riding program.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

Equine Release and Waiver of Liability, Assumption of Risk and Indemnification Agreement

By signing this Equine Release and Waiver of Liability, Assumption of Risk, and Indemnity Agreement ("Agreement"), I represent that I have read this Agreement and that I fully understand the Agreement. "Equine" means a horse, mini horse, pony, mule, donkey, or hinny and "Equine Activities" shall include, but are not limited to, riding, assisting in care, or interacting with Equine, either on or off of the Whispering Manes Therapeutic Riding Center premises. These Equine Activities involve the risk of serious bodily injury, including but not limited to permanent disability, paralysis and even death. I represent that I am, or the person I am the legal guardian of is in good health and proper physical condition to participate in these Equine Activities. I understand the nature and risk of participating in these Equine Activities. I understand that this Release is intended to include all activities whether on or off the Equine.

In consideration of my or my child's/legal ward's participation and/or assistance and/or volunteering in any Equine Activities involving Whispering Manes Therapeutic Riding Center ("Whispering Manes"), I ("Participant" or "Volunteer"), on my own behalf, or through a legal guardian, agree and consent to the following:

RELEASE AND WAIVER OF LIABILITY

I do hereby release Whispering Manes Therapeutic Riding Center and its employees, officers, directors, volunteers and agents (collectively "WMTRC") and all sponsors, partners, agents, subcontractors, donors, (and their officers, directors, and any others acting on their behalf) ("Released Parties"), from any and all damages, losses, liabilities, claims, including any claim of personal injury, death, or injury to, or any loss of personal property ("Claims"), (i) sustained by me or my child while participating in the Equine Activities or (ii) for Whispering Manes' provision or failing to provide Participant or Volunteer with any ambulance service, medical care, nursing care, paramedic care, basic life support care, emergency trauma care, advanced life support care, first aid, emergency communication, emergency transportation, or (iii) for any design, maintenance or repair of any facility or anything or any other act caused by WMTRC or otherwise, while I am in or upon said Whispering Manes' premises or while participating in any Equine Activities. All personal property kept, placed or left on or about the Whispering Manes' premises shall be at my sole risk as to loss, theft, injury or damage and WMTRC shall have no responsibility for such loss, theft, or damage to any such personal property.

ASSUMPTION OF RISK

I hereby acknowledge and agree that horses, mini horses, ponies, Equine, riding, hacking, cantering, galloping, obstacle courses, and/or any other equine activities, including but not limited to riding, assisting in care, or interacting with Equine, either on or off of the Whispering Manes Therapeutic Riding Center premises. ("Equine Activities") are dangerous and involve risk of serious injury and/or death and/or property damage or loss and that the Equine Activities are extremely dangerous and ultra-hazardous. I consciously and voluntarily assume all such risks, dangers and hazards inherent in these Equine Activities and assume the same risks for any invitees, guests, including minor children or legal wards who participate and/or volunteer in such Equine Activities wherever located.

I understand that I have given up substantial rights by signing this Agreement and have signed it freely and without any inducement or assurance of any nature. I intend this to be a complete and unconditional release of all liability to the greatest extent allowed by law which includes the release of liability of WMTRC and Released Parties. I further agree that if any portion of this Agreement is held to be invalid the balance, notwithstanding, shall continue in full force and effect.

INDEMNIFY AND HOLD HARMLESS

I hereby agree to indemnify, defend and hold harmless WMTRC, and any Released Parties for any Claims related to any liability relating to personal injury or injury to real or personal property of any kind arising out of the ordinary negligence, willful or wanton negligence, or intentional acts of the undersigned while at Whispering Manes' premises or while a Participant or Volunteer is involved with any Equine Activities, wherever located.

DAMAGES

I agree to be responsible for all damages caused by me, my animals, invited minor children or anyone with me while on the Whispering Manes' premises, property or grounds or while participating and/or volunteering in any Equine Activities.

COST OF ENFORCEMENT

I agree to be liable for all WMTRC persons and any Released Parties for reasonable attorneys' fees and other costs resulting from my breach of any provision of this Release and Waiver.

CHOICE OF LAW AND VENUE

I agree that this Agreement shall be governed by and construed in accordance with the laws of the State of Florida. By signing this Agreement, I agree to be exclusive jurisdiction of the courts of the State of Florida and that the only venue for any legal proceedings shall be Miami, Florida.

WARNING

CAUTION: HORSEBACK RIDING CAN BE DANGEROUS. RIDE AT YOUR OWN RISK.
Under Florida Law, an equine activity sponsor or equine professional is not liable for any injury to, or the death of, a participant or a volunteer in equine activities resulting from the inherent risks of equine activities.
FLORIDA STATE STATUTE 773.04

If the below Participant or Volunteer is a minor or legal ward, then a LEGAL GUARDIAN MUST sign below on behalf of the minor/legal ward. NOTE: No minor/legal ward will be allowed to participate or volunteer in the Activities unless accompanied by an adult.

Date: _____
Participant/Volunteer Signature: _____
Printed Participant/Volunteer Name: _____
Date of Birth of Participant/Volunteer: _____
If applicable, Legal Guardian Signature: _____
Printed Legal Guardian Name: _____

Information for Physician

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 following Medical Historyand Physician's Statement Form. Please note that the following conditions, if present, may represent precautions and/or contraindications to equine assisted activities. Therefore, when completing this form, contraindications to equine assisted activities. Therefore, when completing this form,

Orthopedic

Atlantoaxial Instability- include neurologic signs
Coxarthrosis
Cranial Defects
Heterotropic 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 5 years
Indwelling catheters/ medical equipment
Medications- photosensitivity
Poor endurance
Skin breakdown

Medical/Psychological

Allergies
Animal abuse
Cardiac conditions
Physical/ sexual/ emotional abuse
Blood pressure control
Dangerous to self or others
Exacerbations of medical conditions (RA, MA)
Fire setting
Hemophilia
Medical Instability
Migraines
PVD
Respiratory compromise
Recent Surgeries
Substance Abuse
Thought control disorders
Weight control disorder

I hereby authorize _____ (person or facility) to release information from the records of _____ DOB:_____

(name of participant)

The information is to be released to: Whispering Manes Therapeutic Riding Center and/or its agents, for the purpose of developing an equine assisted activity program for the above named participant.

This release is valid and can be revoked, in writing, at my request.

Signature:_____ Date: _____
Print Name:_____

Thank you very much for you assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact a staff member at the address or phone number provided below.

PHYSICIAN'S STATEMENT

Please complete this form in its entirety or it will be returned to you.
Enrollment cannot be finalized without a current signed statement on file.

Participant: _____ DOB: _____Height: _____" Weight:_____lbs

Address:_____
City:_____ State:_____ Zipcode:_____

Diagnosis: _____ Date of Onset:_____
Medications:_____

Seizure Type: _____Controlled: Y ☐ N Last Seizure Date:_____

Shunt Present:Y N Last Revision Date:_____ Tetanus Shot: Y N Date:_____
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 Radiographs Date: _____ Result: Neg Pos
Negative for Neurological Symptoms of Atlanto Axial Instability: Y N

Indicate if patient has a problem and/or any past or prospective surgeries in any of the following areas. If checked please comment

☐ Allergies_____
☐ Behavioral/Emotional_____
☐ Cardiovascular_____
☐ Genitourinary_____
☐ Integumentary_____
☐ Neurological_____
☐ Pain_____
☐ Tactile_____
☐ Visual_____
☐ Auditory/Speech_____
☐ Balance_____
☐ Gastrointestinal_____
☐ Immunological_____
☐ Muscular_____
☐ Orthopedic_____
☐ Psychological_____
☐ Thinking/Cognition_____
☐ 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 Whispering Manes Therapeutic Riding Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the Whispering Manes Therapeutic Riding Center for ongoing evaluation to determine eligibility for participation.

Name: _____ MD DO NP PA Other: _____
Signature: _____ Date: _____
Address: _____
_____
Phone:_____ License/UPIN:_____