



Equestrian Center  
16544 A. South HWY-169  
Oologah, OK 74053  
(918) 371-1750  
FAX: (918) 371-1930

## LIABILITY RELEASE

---

*(participant's name)*

would like to participate in the Bit-by-Bit therapeutic horseback riding program. I acknowledge the risks and potential risks of horseback riding. However, I feel that the possible benefits to myself/ my son/ my daughter/ my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs, and assigns, executors or administrators, waive and release forever all claims for damages against Bit-by-Bit therapeutic horseback riding program, Rogers State University, it's Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/ my son/ my daughter/ my ward may sustain while participating in Bit-by-Bit's therapeutic horseback riding program.

*Under Oklahoma 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 from the inherent risks of equine activities.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(participant, parent, or guardian)*

Print Name: \_\_\_\_\_

### PHOTO RELEASE

I  DO

I  DO NOT

consent to and authorize the use and reproduction by Bit By Bit (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 center.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(participant, parent, or guardian)*

## AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

Participant                       Staff                       Volunteer

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

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

Physician's Name: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

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

*In the event of an emergency, contact:*

Name: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_ Relation to Participant: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_ Relation to Participant: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_ Relation to Participant: \_\_\_\_\_

### CONSENT PLAN

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize \_\_\_\_\_ to:  
*(Center's Name)*

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

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

*Client, Parent or Legal Guardian  
Signed in presence of center staff*

### NON-CONSENT PLAN

I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services, or while being on the property of the agency.

- Parent or legal guardian will remain on site at all times during equine assisted activities
- In the event emergency aid/treatment is required, I wish the following procedure to take place:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Non-Consent Signature: \_\_\_\_\_

*Client, Parent or Legal Guardian  
Signed in presence of center staff*

## PARTICIPANT'S APPLICATION AND HEALTH HISTORY

### GENERAL INFORMATION

Participant: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: M F

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

Phone: ( ) \_\_\_\_\_ Alternative Phone #: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

School District: \_\_\_\_\_

School Address: \_\_\_\_\_ School Phone #: ( ) \_\_\_\_\_

Parent/Legal Guardian/Caregivers: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

How did you hear about the program? \_\_\_\_\_

### IMMEDIATE CONTACTS (for any reason)

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Relation to Participant: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Relation to Participant: \_\_\_\_\_

### 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, over-the-counter: name, dose and frequency)

---

---

---

---

---

---

---

---

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

**PHYSICAL FUNCTION** (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

---

---

---

---

---

---

---

---

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

---

---

---

---

---

---

---

---

**GOALS** (i.e. Why are you applying for participation? What would you like to accomplish?)

---

---

---

---

---

---

---

---

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

## PARTICIPANT'S CONSENT FOR RELEASE OF INFORMATION

I hereby authorize: \_\_\_\_\_  
*(person or facility)*

to release information from the records of: \_\_\_\_\_ DOB: \_\_\_\_\_  
*(participant's name)*

The information is to be released to: \_\_\_\_\_  
*(center or therapist's 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
- Occupational 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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 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 indicated above.

Sincerely,

## 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 Onset: \_\_\_\_\_  
 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:* AtlantoDens Interval X-rays Date: \_\_\_\_\_ Result: -- +  
 Neurologic Symptoms of AtlantoAxial Instability: \_\_\_\_\_

*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			

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

Name/Title: \_\_\_\_\_ MD DO NP PA Other: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: ( ) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_