Thank you for your interest in Therapeutic Riding At Centenary!

We have enclosed the registration paperwork required of all applicants. Please complete all forms as indicated and return them to the TRAC office as soon as possible.

The Application and Health History should be completed by the client or client’s parent/caregiver. This includes the following releases:
- The liability release must be signed and dated.
- TRAC educational photo release must be signed and dated. This covers only photographs/videos used for the purpose of educating trainee instructors. This materials will not be used for any other purpose.
- The commercial photography release is optional.

The Medical History and Physician’s Statement must be submitted to your doctor for signature.

The Authorization for Emergency Medical Treatment must be completed, dated and signed in two places.

When the completed paperwork is returned to the office, we will contact you to arrange for an evaluation session. This will be conducted as a private session by a PATH certified instructor with volunteer aides to handle the horse and assist the client. If it is decided that therapeutic riding is safe and potentially beneficial for the client, a riding time will be established.

Please be aware that there are certain precautions and contraindications associated with therapeutic riding. These are listed on the back of the Medical History and Physician’s Statement. If you have any questions, please feel free to call us. The Eligibility Guidelines for TRAC are on the reverse side of this letter.

Once again, welcome to TRAC! We look forward to meeting you soon!

Sincerely,

Octavia J. Brown
Octavia J. Brown, Ed.M., DHL.
Director, TRAC
Participant Application and Health History

Client name ___________________________ DOB ___________ Age ________

Address _____________________________________________________________

Street town state zip

e-mail ____________________________

Phone: h ______________________ w_______________________ cell______________________

Employer/School

_________________________________________________________________________________

Address

_______________________________________________________________________________________

Parent names ________________________________

If applicable: Legal Guardian ____________________________

Address ____________________________________________________________________________

Phone: h ______________________ w_______________________ cell______________________

Referral source ____________________________ phone_________________________

How did you hear about our program?

_______________________________________________________________________________________
**Health History**

Diagnosis __________________________________________ date of diagnosis ________________

Seizure history, if any

________________________________________________________________________________________________________________________________________________

Please indicate current or past special needs in the following areas:

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<th>Y</th>
<th>N</th>
<th>Comments</th>
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<td>Vision</td>
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<td>Hearing</td>
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<td>Circulation</td>
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<td>Emotional/Mental Health</td>
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<tr>
<td>Allergies</td>
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</tbody>
</table>

**MEDICATIONS** (include prescription, over-the-counter with name, dose and frequency)

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

**LIABILITY RELEASE**

It is understood that, being aware of the risks and exposures to personal injury involved through equestrian activities, I hereby release TRAC, its staff and volunteers, Centenary University and its students and/or employees assisting in any official capacity on their behalf, from all and every claim for damages which may occur to me or property in any connection with any lesson, clinic, practice, schooling or any work with horses on the University grounds or away from the grounds of the Centenary University equestrian Center, Long Valley, New Jersey.

Signature: __________________________________________ date _____________________

Client over 18, parent or legal guardian
EDUCATIONAL PHOTOGRAPHY RELEASE (Mandatory)

I hereby consent to allow Therapeutic Riding At Centenary/Centenary University to use photographs and/or videos of me/my child exclusively for the purpose of educating Centenary University student instructors. I understand that these will not be used for any promotional purpose without my written permission.

Signature _________________________________________________  Date _______________________

PROMOTIONAL PHOTOGRAPHY RELEASE (Optional)

I hereby irrevocably consent _______ do not consent _______ to allow Therapeutic Riding At Centenary/Centenary University to use photographs and/or videos of me/my child for any purpose, and in any manner without limitation, including for print media, television, exhibition, publication and any trade or advertising purpose, providing such uses are not made so as to constitute a direct endorsement by me or my child of any product or service.

Signature ______________________________________________  Date _____________________________

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

PSYCHOLOGICAL 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?)

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

Participant’s Medical History & Physician’s Statement

Participant: ________________________________ DOB: _________ Height: _________ Weight: _________

Diagnosis: _____________________________________________ Date of Onset: _____________________

Past/Prospective Surgeries: ________________________________________________________________

Medications: ______________________________________________________________________________

Purpose of medications ______________________________________________________________________

Seizures? _____________________________ 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: Result of neurologic exam to check for symptoms of AtlantoAxial Instability:

__________________________________________________________________________________________

Please indicate current or past special needs in the following systems/areas, including surgeries:

<table>
<thead>
<tr>
<th>System</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditory</td>
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<td>Visual</td>
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<td>Cardiac</td>
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<tr>
<td>Circulatory</td>
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</tbody>
</table>
To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that TRAC 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: __________________________
Dear Health Care Provider:

One of your patients is interested in participating in supervised equine activities. In order to safely provide this service, we request that you complete 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.

### Precautions and/or Contraindications for Therapeutic Riding Activities:

**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
- Severe Sensory Deficit
- Seizure (uncontrolled)
- Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromelia

**Medical**
- Severe 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 setting
- Hemophilia
- Medical Instability
- Migraine (severe)
- PVD
- Respiratory compromise
- Recent surgeries
- Substance abuse
- Thought control disorders
- Weight control disorders

**Other**
- Age – under 4 years
- Indwelling catheter/Medical equipment
- Medications – i.e. photosensitivity
- Poor endurance
- Skin breakdown

Thank you very much for your assistance. If you have any questions or concerns regarding this patient’s participation in equine activities, please feel free to contact us at the address and phone indicated below.

Sincerely,

**Octavia J. Brown**
Octavia J. Brown, Ed.M., DHL.
Director, TRAC
Authorization for Emergency Medical Treatment Form

☐ Participant  ☐ Staff  ☐ Volunteer

Name: ____________________________________________________ DOB: _______________

Phone: (h) _______________ (c) _______________ (w)__________________________

Address: ___________________________________________________________________

Street       Town       State and Zip

Caregiver information: Name ________________________________ (Please fill in below if
different from above information)

Phone: (h) __________________  (c) _______________________(w)______________________

Address: ___________________________________________________________________

Street       Town       State and Zip

Physician’s Name, town, Phone: _____________________________________________________

Health Insurance Company: __________________________________________________________

Policy #: _________________________________  Group # _________________________________

Allergies to medications or other:

___________________________________________________________________________

Current medications and dosage:

___________________________________________________________________________

In the event of an emergency, contact:

Name: ________________________________ Relation: ____________ Phone: ________________

Name: ________________________________ Relation: ____________ Phone: ________________
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 TRAC personnel to:

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 none of the person(s) above can be reached.

Date: __________ Consent Signature: ________________________________________________

Client/Volunteer/Staff, Parent (if under 18) or Legal Guardian

To my knowledge, the information I have given on this form is complete and accurate.

Date: __________

Consent Signature: ______________________________________________________________

Client/Volunteer/Staff, Parent (if under 18) or Legal Guardian