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 Brown

Dr. Octavia J. Brown
TRAC Program Director
PATH Master Instructor
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>
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<th>Comments</th>
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<td>Allergies</td>
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Continue on back
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 College 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 college grounds or away from the grounds of the Centenary College 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 College to use photographs and/or videos of me/my child exclusively for the purpose of educating Centenary College 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 College 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 the check for symptoms of AtlantoAxial Instability:

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<tr>
<th>Systems/Areas</th>
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<th>Comments</th>
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<td>Other</td>
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</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 Arthritis
- 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