Centenary College
400 Jefferson Street
Hackettstown, NJ 07840
908-852-1400 x 2174 Fax: 908-813-1984

T R A C

Therapeutic Riding At Centenary

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

TRAC, Centenary College
400 Jefferson Street
Hackettstown, NJ 07840
908-852-1400 ext. 2174 Fax: 908-813-1984

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:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Cognitive			
Allergies			

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:

____

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

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

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: ____________________________

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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

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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