Healing Horses Rider Package Check List

Rider: __________________________ Date: __________________ Class: ______2023________

All pages of this form (pg. 2-5) are required, completed, checked, signed and dated as indicated prior to the start of rider participation.

If the rider has a primary or secondary diagnosis a doctor's release will be required due to PATH Intl. standards and the safety of the participant.

Participant/Volunteer/Employee Manual Verification

I attest that I have read and understand this manual in its entirety. I will abide by all rules and regulations at all times. If a parent or guardian is signing on behalf of a minor, they take full responsibility for carrying out these policies with the minor(s) listed below. I/We understand that if these rules are broken, I/We may be asked to leave immediately, per the instructor's discretion, and may be found to have grounds for dismissal. Any questions or concerns can be answered by a Director during operating hours, hhkauai@gmail.com or 808-634-3896.

_________________________________ ______________________________

Printed
Name of Employee/Participant Signature of Employees/Participant/ Parent/Guardian

____

Date

Minor(s) ______________ ______________ ______________ ______________
Equine Therapy Inc. dba Healing Horses Kauai

Healing Horses Client Registration

Date_____________

Participant Name: _________________________ Phone: _______________________________

Address____

Email ____

DOB______________ Age________ Height__________ Weight_______ Gender M F

Participant's occupation/ school grade level____

Affiliate Programs (if applicable)____

Primary Diagnosis__________________________________ Date of Onset _______________

Secondary Diagnosis________________________________Date of Onset _______________

Medications Taken____

Allergies____

Skin sensitivity____

Seizures (if applicable please describe frequency & type)____

Mobility Status & Physical Function (walks unassisted, assisted, walker, wheelchair, braces, etc)

____

Communication (verbal, non-verbal, signs, board, etc) ___________________________________

Behaviors (impulsive, fearful, frustration tolerance) ______________________________________

____

Limitations____

Check/Circle all that apply: __ Glasses/Contacts __ Hearing Problem / Device

__ Neurological System Issues: __Head Injury __ Spine Injury __ CP __ Paralysis

__ Sensory Processing __ Cognitive Processing __Communication Issues

__ Emotional / Mental Health __Pain __ Other: ____

__ Circulatory System Issues : Murmur / BP / Cholesterol / PAD / Sickle Cell / Other: _______________

__ Respiratory System Issues : Asthma / COPD / Emphysema / Other: ___________________________

__ Integumentary System Issues: Eczema / Psoriasis / Tumors / Other: ___________________________

__ Immune Systems Issues: Lupus / Diabetes / Other: _____________________________________

__ Digestive System Issues: Feeding Tube / Other : _______________________________________

__ Excretory / Urinary System Issues: Catheter / Colostomy / Other:_________________________

__ Endocrine System Issues: Lymph Nodes ____

__ Reproductive System Issues: ____

__Muscular-Skeletal System Issues: Neck Back/Spine Shoulder/Arm Elbow/Forearm

Wrist/Hand/Finger Hip/Thigh Knee Calf/Ankle Foot/Toes

Other: ____

For those with Down Syndrome: AtlantoDen Interval Xrays Date_________ Result + / -

Neurological Symtpoms of AtlantoAxial Instability: ____________________________________

Healing Horses Client Registration

Availability for the Healing Horses Program (Circle all available times and days)

Monday:	AM	PM	Friday:	AM	PM
Tuesday:	AM	PM	Saturday:	AM	PM
Wednesday:	AM	PM	Sunday:	AM	PM
Thursday:	AM	PM			

Personal Goals **(Fill in the areas that apply. Why are you applying? What do you want to accomplish?)**

Physical____

Cognitive____

Social/Behavioral____

Life Skills____

Other____

Names of parents/guardian:

Father______________________ Cell______________________ Email______________________

Mother______________________ Cell______________________ Email______________________

Emergency Contact:

Name______________________________ Relationship __________________

Phone___________________________________ Cell______________________

Preferred Medical Facility: _________________ Physicians name: ________________

Parent occupation and employer:

Father____ Work Phone______________________

Mother____ Work Phone______________________

Program Tuition Payment Details

I, ____________________ ,authorize Healing Horses to charge my credit card for any overdue payments.

Name on Card_____________________ Cardholder signature_______________________________

Billing zip code_________ Card Number__________________________ Exp._______ Code _____

Circle how you prefer to pay: In-person: Cash / Check* Online: Paypal / Credit Card

*Make checks payable to Healing Horses Kauai

I understand and agree that all paperwork must be up to date, renewed annually and that all tuition is to be paid prior to the start of each session.

Signature of Rider or Legal Guardian_______________________________ Date___________

Name of Participant (Age) ______________________________(_____) Date of Birth ___/___/_____
Height _______ Weight _______ Shirt Size: YS YM YL A-SM A-MD A-LG A-XL

Phone ________________________________ **Email____**

Name of Parent/Guardian/Caretaker (if applicable) ____

Liability Release
Name of Participant/Parent/Guardian/Conservator ______________________________________
I acknowledge the risks and potential risks for horseback riding and activities in and around a facility where horses, other animals and farm machinery are kept and operated. I, the undersigned, understand the Hawaii Law (Act 248, 1994 Hawaii Legislative Session, effective June 29, 1994) limits the civil liability of persons sponsoring equine (horse, pony, mule, donkey, or hinney) activities. Risks include but are not limited to (1) the propensity of an equine to behave in ways that may result in injury or death to persons on or around them, (2) the unpredictability of an equine's reaction to such things as sounds, sudden movement and unfamiliar objects, persons or animals, (3) hazards such as surface and subsurface conditions, (4) collisions with other equines or objects, and (5) the potential negligence of another participant, such as failing to maintain control over the equine, or not acting within the participant's ability.
Knowing the potential risks to person and damage to personal property, I expressly choose to assume these risks. I feel that the possible benefits to me/my son// my daughter/my ward are greater than the risk assumed. Intending legally to bind myself, my heirs, my successors, representatives and assigns, executors or administrators, I hereby waive and release forever all claims and causes of action for loss or damages of any kind against Healing Horses Kaua'i, its Board of Directors, Instructors, Therapists, Aids, Volunteers, and Employees for any and all injuries and losses that I/my son// my daughter/my ward may sustain while participating in the Healing Horses Kaua'i program. This release includes without limitation the risk of negligent instruction and supervision. I engage in activities at Healing Horses Kaua'i voluntarily with knowledge of the risks and I assume all risk of injury, death, and property damage that may result. I agree to bear any loss myself. I acknowledge that Healing Horses Kaua'i and the property owners are materially relying on this waiver and assumption of risk in allowing me/my son// my daughter/my ward to participate in activities at Healing Horses Kaua'i.

Date _____/_____/_________ **Signature________________________________**
(Participant, Parent/Caregiver if minor)

Confidentiality Agreement
I understand that all the information (written and verbal) about participants at Healing Horses Kauai is confidential and not to be shared with anyone without expressed written consent of the participant (parent/guardian is the case of a minor.)

Date _____/_____/_________ **Signature________________________________**
(Participant, Parent/Caregiver if minor)

Photo and Video Release
_____ I consent to and authorize _____ I do not consent to nor do I authorize
The use and reproduction by Healing Horses Kauai of any audio/visual materials taken of me/my son/my daughter/my ward for distribution to the public for promotional printed materials, educational activities or for any other use for the benefit of the program.

Date _____/_____/_________ **Signature________________________________**
(Participant, Parent/Caregiver if minor)

Possible Reasons for Client Discharge

Please be advised of the following reasons that may lead to discharge from the riding program.

1. The client has reached all of their goals and is ready to graduate.
2. The client's potential to maintain head and neck control while riding presents a safety concern.
3. Inability to follow directions is interfering with progress toward goals.
4. Uncontrolled and/or inappropriate behavior that constitutes a safety risk to client, staff and/or horse.
5. Client exceeds weight that can safely be managed by staff, volunteers, and/or horses.

* List physical/medical/mental/cognitive/emotional/developmental diagnoses/disabilities here:
_________________________, ___________________, ______________________

6. Any change in the client's medical, physical, cognitive, or emotional condition that makes therapeutic riding inappropriate.
7. Three scheduled appointments are missed without prior cancellation.
8. Non payment of fees as originally agreed.

I understand and agree with the possible reasons for client discharge.

Signature of Client or Legal Guardian: ____________________________ Date: ___________

<u>Demographic Information for Grant Writing Purposes</u>

Activity: ___ Lesson, ___ Camp, ___ Photos, ___ Private Event Onsite, ___ Outreach Event -Off Site

Type of Lesson: Non-Therapeutic ___ Traditional Riding
Therapeutic: ___Mental, ___ Physical, ___Developmental, ___Cognitive

Age Category: ___ Toddler(0-4), ___ Preschool(4-5), ___ Elementary (6-10), ___ Middle(11-13), ___ High school(14-17), ___ Adult(18+), ___(Senior Citizen (65+)

Residency: ___ Resident, ___Inter-Island, ___ Mainland (_____), State **___ International (_____________)** Country

Descriptor: ____ None; ___ Legally Disabled; ___ Functional Paralysis (type: ____________); ___Low Income (ALICE); ___ Poverty Population (FPL); ____ Foster Youth; ___ Survivors of Violence; _____ Single Parent Household; ___Homeless; ___ Prisoner/At-Risk of Incarceration; ___ Ethnic Minorities; ___ Indigenous/Tribal Communities; ___ Limited English Proficiency; ___ Migrant Worker; ___ LGBTQ; ___ Military Service Members and/or Veterans; ___ Rural Residents; ___ Other

How did you hear of this event: ___ Word of Mouth; ___ Flier; ___ Concierge; ___ Website; ___ Radio (Station: __________); ___ Print Ad (Source:__________); ___ Social Media (Source:__________)