



Healing Horses Rider Package Check List

Rider: _____ **Date:** _____ **Class/Year:** _____

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 Symptoms 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 Kauai, 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 Kauai program. This release includes without limitation the risk of negligent instruction and supervision. I engage in activities at Healing Horses Kauai 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 Kauai 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 Kauai.

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: _____

Demographic Information for Grant Writing Purposes

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 (____), ___ International (____)
State 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: _____)**