FULL CIRCLE FARM
THERAPEUTIC HORSEMANSHIP

80 Edgell Road
Newport NH 03773
603-863-2952
info@fcftherapeutic.org
www.fcftherapeutic.org

Participant's Application & Health History

Participant: _____

DOB: _____ Age: _____ Ht: _____ Wt (180 max): _____ Gender: M F

Address: _____

Email: _____ Phone: _____ Cell: _____

Employer/School:_____

Address:_____ Phone: _____

Parent/Legal Guardian:_____

Caregivers:_____

Address (if different):_____Phone:_____

Referral Source:_____Phone:_____

How did you hear learn of our program?_____

HEALTH HISTORY

Diagnosis: _____ Date of Onset: _____

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			
Thinking/Cognition			
Allergies			

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

Describe your abilities/difficulties in the following areas (including assistance required or equipment needed):

PHYSICAL FUNCTION (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

PSYCHO/SOCIAL FUNCTION (e.g., 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?)

Signature: _____ Date: _____

PHOTO RELEASE

☐ I DO ☐ I DO NOT

consent to and authorize the use and reproduction by Full Circle Farm of any and all photographs and any other audio/visual materials taken of participant and/or me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Client, Parent or Legal Guardian

Signed in the presence of center staff

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Participant Agreement and Liability Release Form

For: FULL CIRCLE FARM THERAPEUTIC HORSEMANSHIP
80 Edgell Rd. Newport NH 03773

This form must be completed by and for each participant.

PLEASE READ CAREFULLY BEFORE SIGNING:
SERIOUS INJURY MAY RESULT FROM YOUR PARTICIPATION IN THIS ACTIVITY. Full Circle Farm Therapeutic Horsemanship DOES NOT GUARANTEE YOUR SAFETY OR THAT OF YOUR HORSE. IT IS HEREBY AGREED TO AS FOLLOWS THAT:

A. REGISTRATION OF RIDERS AND AGREEMENT PURPOSE - I, the following individual hereinafter known as the "RIDER", and the parents or legal guardians thereof if a minor, do hereby voluntarily request and agree to participate in horse riding on premises Full Circle Farm Therapeutic Horsemanship, and that this RIDER will ride his/her own horse or one borrowed or leased by RIDER'S own arrangement today and on all future dates:
RIDER NAME & AGE (if under 18)_____

B. AGREEMENT SCOPE AND TERRITORY AND DEFINITIONS – This agreement shall be legally binding upon me the registered RIDER, and the parents or legal guardians thereof if a minor, my heirs, estate, assigns, including all minor children, and personal representatives; and it shall be interpreted according to the laws of NH.

The term "HORSE" herein shall refer to all equine species. The term "HORSEBACK RIDING" or "RIDING" herein shall refer to riding or otherwise handling of horses, ponies, mules, or donkeys, whether from the ground or mounted. The term "RIDER" shall herein refer to a person who rides a horse mounted or otherwise handles or comes near a horse from the ground. The terms "I", "me", "my" shall herein refer to the above registered rider and the parents or legal guardians thereof if a minor.

C. NATURE OF RIDING HORSES - No horse is a completely safe horse. Horses are 5 to 15 times larger, 20 to 40 times more powerful, and 3 to 4 times faster than a human. If a rider falls from a horse to the ground it will generally be at a distance of 3 1/2 to 5 1/2 feet, and the impact may result in injury to the rider. Horseback riding is the only sport where on much smaller, weaker predator animal (human) tries to impose its will on, and become one unit of movement with, another much larger, stronger prey animal with a mind of its own (horse) and each has a limited understanding of the other. If a horse is frightened or provoked it may divert from its training and act according to its natural survival instincts which may include, but are not limited to: stopping short, changing directions or speed at will; shifting its weight; bucking; rearing; kicking; biting; or running from danger.

D. RIDER RESPONSIBILITY - Upon mounting a horse and taking up the reins, the RIDER is in primary control of the horse. The RIDER'S safety largely depends upon his/her ability to carry out simple instructions, and his/her ability to remain balanced aboard the moving animal. The RIDER shall be responsible for his/her own safety.

E. CONDITIONS OF NATURE - Full Circle Farm Therapeutic Horsemanship is NOT responsible for total or partial acts, occurrences, or elements of nature that can scare a horse, cause it to fall, or react in some other unsafe way. SOME EXAMPLES ARE: thunder, lightning, rain, wind, wild and domestic animals, insects, which may walk, run, fly near, bite and/or sting a horse or person; and irregular footing on out-of-door groomed or wild land which is subject to constant change in condition according to weather, temperature, and natural and man-made changes in landscape.

F. INSPECTION OF PREMISES - RIDER has inspected Full Circle Farm Therapeutic Horsemanship facilities and trails and is satisfied that all premises conditions are reasonably safe for RIDER'S intended purpose, usage and presence upon the Full Circle Farm Therapeutic Horsemanship premises.

H. PROTECTIVE HEADGEAR WARNING - I have been fully warned and advised by Full Circle Farm Therapeutic Horsemanship that the RIDER should purchase and wear protective headgear (riding helmet), and that the wearing of such headgear while mounting, riding, dismounting, and otherwise being around horses, may prevent or reduce severity of some head injuries and even prevent death from happening as the result of a fall or other occurrence.

I. LIABILITY RELEASE - In consideration of Full Circle Farm Therapeutic Horsemanship allowing my participation in this activity, under the terms set forth herein, I, the RIDER, and the parent or guardian thereof if a minor, do agree to hold harmless and release Full Circle Farm Therapeutic Horsemanship, its owners, agents, employees, officers, members, premises owners, insurers, and affiliated organizations from legal liability due to Full Circle Farm Therapeutic Horsemanship ordinary negligence; and I do further agree that except in the event of Full Circle Farm Therapeutic Horsemanship gross negligence and willful and wanton misconduct, I shall not bring any claims, demand, legal actions and causes of action, against Full Circle Farm Therapeutic Horsemanship and/or its associates, for any economic and non-economic losses due to bodily injury, death, property damage, sustained by me and/or my minor child or legal ward in relation to the premises and operations of Full Circle Farm Therapeutic Horsemanship, to include while riding, handling, or otherwise being near horses owned by or in the care, custody and control of Full Circle Farm Therapeutic Horsemanship.

All Riders and Parents or Legal Guardians must sign below after reading this entire document:

SIGNER STATEMENT OF AWARENESS

I/WE, THE UNDERSIGNED, HAVE READ AND DO UNDERSTAND THE FOREGOING AGREEMENT, WARNINGS, RELEASE AND ASSUMPTION OF RISK. I/WE FURTHER ATTEST THAT ALL FACTS RELATING TO THE APPLICANT ARE TRUE AND ACCURATE.

SIGNATURE OF RIDER (Parent must sign for rider under 18): _____

DATE:_____

Date of birth: _____

SIGNATURE OF PARENT, CAREGIVER OR GUARDIAN:_____

_____ DATE: _____

(Please print name)

Address in full: _____

Home phone: _____ Work phone: _____

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Authorization for Emergency Medical Treatment

_____Participant _____Staff _____Volunteer

Name: _____ DOB: _____ Phone: _____
Physician's Name: _____ Preferred medical facility: _____
Health insurance co: _____ Policy #: _____
Current allergies, medications, and health concerns: _____
_____

In the event of an emergency:
Emergency contact 1: _____ Relationship: _____
Home Ph: _____ Work Ph: _____ Cell Ph: _____
Emergency contact 2: _____ Relationship: _____
Home Ph: _____ Work Ph: _____ Cell Ph: _____

In the event that 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 Full Circle Farm 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.

CONSENT PLAN
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 the person(s) listed cannot be reached.**

Date: _____ Consent Signature _____

Client, Parent, or Legal Guardian

NON-CONSENT PLAN
I do not give consent for emergency medical aid/treatment in the case of illness or injury and agree to be present with the participant during the process of receiving services or while being at Full Circle Farm

Date: _____ Consent Signature _____

Client, Parent, or Legal Guardian

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Consent for Release of Information

I hereby authorize: _____ to release information
(Person or facility)

from the records of: _____ DOB: _____
(Participant's name)

The information is to be released to Full Circle Farm Therapeutic Horsemanship for the purpose of developing an equine activity program for the above-named participant. The information to be released is indicated below:

☐ Medical history

☐ Physical therapy evaluation, assessment and program plan

☐ Speech therapy evaluation, assessment and program plan

☐ Mental health diagnosis and treatment plan

☐ Individual Habilitation Plan (I.H.P.)

☐ Classroom Individual Education Plan (I.E.P.)

☐ Psychosocial evaluation, assessment and program plan

☐ Cognitive-behavioral management plan

☐ Other: _____

This release is valid for one year and can be revoked, in writing, at my request.

Signature: _____ Date: _____

Print Name: _____

Relation to Participant: _____

Please send materials to:
Full Circle Farm Therapeutic Horsemanship
80 Edgell Road,
Newport, NH
03773

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Date: _____

Dear Health Care Provider:

Your patient _____
(participant's name)
is interested in participating in supervised equine activities.

In order to safely provide this service, we request that you complete/update the attached Medical History and Physician 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.

Orthopaedic
Atlantoaxial instability (include neurologic symptoms)
Coxarthrosis
Cranial defects
Heterotopic ossification/myositis ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic fractures
Spinal joint fusion/fixation
Spinal joint instability/abnormalities

Neurologic
Hydrocephalus/shunt
Seizure
Spina Bifida/Chiari II malformation/tethered

Other
Age – under 4 years
Indwelling catheters/medical equipment
Medications – e.g. photosensitivity
Poor endurance
Skin breakdown

Medical/Psychological
Allergies
Animal abuse
Cardiac condition
Physical/sexual/emotional abuse
Blood pressure control
Dangerous to self or others
Exacerbations of medical conditions (e.g., RA, MS)
Fire settings
Hemophilia
Medical instability
Migraines
PVD
Respiratory compromise
Recent surgeries
Thought control disorders
Weight control disorders

Thank you for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,
Full Circle Farm Therapeutic Horsemanship

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Physician's Statement

(This form must be signed by the participant's physician)

Participant: _____ DOB: _____ Height:_____ Weight: _____
Address: _____
Diagnosis: _____ Date of Onset: _____
Past/prospective surgeries: _____
Medications: _____
Seizure type: _____ 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: neurologic symptoms of atlantoaxial instability: □Present □Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	Y	N	Comments
Auditory			
Vision			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Orthopedic			
Allergies			
Learning disability			
Cognitive			
Emotional/psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that Full Circle Farm will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Full Circle Farm for ongoing evaluation to determine eligibility for participation.
Name/Title: _____ MD DO NP PA Other _____
Signature: _____ Date: _____
Address: _____
Phone: (___) _____ License/UPIN Number: _____