NEW HOPE EQUINE ASSISTED THERAPY

EMERGENCY MEDICAL TREATMENT
Equestrian/Participant

Please fill out online, then print and take to your physician for signature. This signed form must be brought in prior to rider's first lesson.

Date _____

Participant Name: _____ **DOB:** _____

Address: _____**City:**_____ **Zip** _____

In case if emergency:

Contact: _____ **Relationship** _____ **Phone#**_____

Contact:_____ **Relationship**_____ **Phone#**_____

Preferred Medical Facility: _____

Physician's Name_____ **Phone#**_____

Health Insurance Carrier: _____ **Policy Number** _____

Allergies, Current Medications: _____

_____

Health History to be considered for emergency responders:

_____

_____

_____

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 New Hope, I authorize New Hope Equine Assisted Therapy to:

1. Secure and retain medical treatment and transportation
2. Release participants records upon request to the authorized individuals or agency involved in the medical emergency treatment.

Date: _____ **Consent Signature:** _____

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of New Hope Equine Assisted Therapy. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

Date: _____**Non-Consent Signature:** _____

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Medical Healthcare Professional Statement

Must be completed, signed and diagnosis confirmed by Licensed Medical Professional

Name:_____ DOB: _____ Height: _____ Weight: _____

Seizure Type: _____ Controlled_____ Date of last Seizure:_____

Diagnosis _____

Medications:_____
Shunt Present: Yes No Date of last shunt revision: _____

Past/Prospective surgeries:_____

Mobility: Independent Ambulation Assisted Ambulation Wheelchair

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.

	Y	N	Comments pertaining to horseback riding/Equine interaction
Auditory			
Visual			
Tactile Sensations			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, to my knowledge there is no reason why this person cannot participate in supervised equestrian activities. I understand that New Hope Equine Assisted Therapy will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to New Hope Equine Assisted Therapy for ongoing evaluation to determine eligibility for participation.

***Physician Signature: _____* Licensed Medical Professional MD, DO, NP, PA, Other**

Physicians Name (please print) _____Date: _____

Address: _____

Phone: ( ) _____ *License/UPIN # _____

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