STUDENT APPLICATION FORM

THIS FORM MUST BE COMPLETED IN FULL AND SIGNED
IN ORDER FOR A STUDENT TO PARTICIPATE
(EXCEPT FOR THE PHOTO RELEASE WHICH IS OPTIONAL)

Horsefeathers Therapeutic Equestrian Center, Inc.
1095 VZCR 3611, Edgewood, TX, 75117 Phone/Fax: (903)896-7002
Email: contact@horsefeatherstherapy.org Web: horsefeatherstherapy.org

Date _____

Name _____ Birth Date _____ Age _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work place & Phone _____

School or other educational institution attending _____

Diagnosis _____ Weight _____ Height _____

If under age 18, Name of Parent/Guardian _____

Work Place _____ Work Phone _____

In case of emergency, notify _____ Home Phone _____

Relationship _____ Work Phone _____

Address _____

Physician _____ Phone _____

Hospital and Town Preferred _____

I am/My Child is: ambulatory _____ non-ambulatory _____ verbal _____ non-verbal _____

I am/My Child uses: wheelchair _____ crutches _____ braces _____ other _____

I/My Child: can _____ can not _____ sit independently.

I would like to apply for a sponsorship: Yes _____ No _____

In case of emergency, I give Horsefeathers Therapeutic Equestrian Center, Inc. to secure medical treatment including x-ray, surgery, hospitalization and medication.

Student Signature _____ Date _____
Or if student under 18 years, Parent/Guardian Signature

Make check payable to: **Horsefeathers Therapeutic Equestrian Center, Inc.**
1095 VZCR 3611
Edgewood, TX 75117

FOR OFFICE USE ONLY

Date Application Received _____ Date Student Began Riding _____

HORSEFEATHERS THERAPEUTIC EQUESTRIAN CENTER, INC.

PHOTO RELEASE

For valuable consideration given, which is hereby acknowledged, the undersigned hereby grants to Horsefeathers Therapeutic Equestrian Center, Inc. (hereinafter referred to as Horsefeathers) permission to take or have taken still and moving photographs and films including television pictures of (name) _____ and consents and authorizes Horsefeathers, its advertising agencies, news media and any other person interested in Horsefeathers and its work, to use and reproduce photographs, films and pictures and to circulate and publicize the same by all means including, but not limited to, newspaper, television, media, brochures, pamphlets, instructional material, exhibits, books and clinical material.

With respect to the foregoing matters, no inducements or promises have been made to us/me to secure our/my signatures to this release other than the intention of Horsefeathers to use or cause to be used such photographs, films and pictures for the primary purpose of promoting and aiding Horsefeathers and its work.

Volunteer Signature _____ Date_____

Parent/Guardian Signature _____ Date _____
(if volunteer under 18 yrs)

NON-CONSENT

I do not give my consent to Horsefeathers Therapeutic Equestrian Center, Inc. to take or have taken still and/or moving photographs and films including television pictures.

Signature of non-consent Volunteer, Parent or Guardian _____Date _____

STUDENT LIABILITY RELEASE

I, undersigned, adult student, or parent or guardian of _____, a minor Student, would like to participate at Horsefeathers Therapeutic Equestrian Center, Inc., (hereinafter referred to as Horsefeathers). I acknowledge the risks and potential for risks of horseback riding. I understand the various populations served by Horsefeathers and understand that teens participating in Horsefeathers Juvenile Intervention Program including adjudicated and/or troubled teens may be acting as volunteers and may be on the Horsefeathers premises. I understand that I/my son/daughter/ward, will be working with and around horses, as well as, riding horses of Horsefeathers; however, I feel that the possible benefits to myself/son/daughter/ward are greater than the risk assumed. I, the undersigned student and/or parent or guardian, hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and forever release, acquit, discharge and hold harmless all claims for damages against Horsefeathers, its board of directors, trustees, agents, instructors, therapists, employees, representatives, successors, assigns, volunteers, owners of the property on which Horsefeathers operates, for any and all manner of claims, demands and damages of every kind or nature whatsoever, which student may now, or in the future have against Horsefeathers, its board of directors, trustees, agents, instructors, therapists, employees, representatives, volunteers, owners of the property on which Horsefeathers operates, successors or assigns on account of any personal injuries and/or personal damages known or unknown, or in anyway growing out of, the acts of Horsefeathers, its board of directors, trustees, agents, instructors, therapists, employees, representatives, volunteers, owners of the property on which Horsefeathers operates, successors or assigns.

I understand that under the *Texas Equine Liability Act (Chapter 87, Civil Practice and Remedies Code), an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities.*

Student Signature _____ Date _____

If under 18 years, Parent/Guardian Signature _____ Date _____

HORSEFEATHERS THERAPEUTIC EQUESTRIAN CENTER, INC.
1095 VZCR 3611, Edgewood, TX 75117 (903)896-7002

STUDENT'S MEDICAL HISTORY AND PHYSICIAN STATEMENT

Student's Name _____ Date of Birth _____

Address _____ Height _____

Parent/Guardian _____ Weight _____

Diagnosis _____ Date of Onset _____

Medications _____

Tetanus Shot Yes _____ No _____ Date of Shot _____

Seizure Type _____ Controlled _____ Date of last seizure _____

**For Persons with Down Syndrome:
Cervical X-ray for Atlantoaxial Instability Positive ____ Negative ____ Date of X-ray _____

Before being accepted as a student, it is essential that the questions are thoroughly and completely answered so that each student's abilities and limitations are given due consideration by Horsefeathers trained Instructor(s), the student's Physician and Therapist.

Special Precautions _____

_____.

Specific body movements or positions NOT to be attempted _____

Specific body movements or positions desired _____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation Yes ____ No ____ Crutches Yes ____ No ____
Braces Yes ____ No ____ Wheelchair Yes ____ No ____

PLEASE SEE REVERSE SIDE OF THIS PAGE

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. I understand that the therapeutic riding center 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, Speech, Psychologist, etc.) in the implementing of any effective equestrian/hippotherapy program**.** THIS FORM MUST BE SIGNED BY ATTENDING PHYSICIAN. WE CANNOT ACCEPT FAXED SIGNATURES, SIGNATURE STAMP OR THE SIGNATURE OF ANY THERAPIST, PHYSICIAN ASSISTANT OR A NURSE PRACTITIONER.

Physician's Name (Please Print) _____

Physician's Signature _____ Date _____

Address _____ Phone _____

City _____ State _____ Zip _____

This form is valid for a period of one (1) year from date signed.

Information for Physician

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Neurologic

Hydorcephalus/shunt
Spina Bifida
Tethered Cord
Chiara ll Malformation
Hydromyelia
Paralysis due to Spinal Cord Injury
Seizure Disorders

Medical/Surgical

Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident)

Secondary Concerns

Behavior problems
Age under two years
Age two – four years
Acute exacerbation of chronic disorder
Indwelling catheter

Horsefeathers Therapeutic Equestrian Center, Inc.

STUDENT AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Name _____ Birth Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

If under age 18, Name of Parent/Guardian _____

Work Place _____ Work Phone _____

Attending Physician _____ Phone _____

Address _____

Preferred Medical Facility _____

Health Insurance Company_____ Policy Number _____

Describe any medical condition requiring special precautions or treatment _____

_____.

List any medications and dosage _____

In case of medical emergency, the undersigned student authorizes Horsefeathers Therapeutic Equestrian Center, Inc., to secure and retain such medical assistance and transportation as they determine to be necessary and proper.

In case of medical emergency, the undersigned student authorizes Horsefeathers Therapeutic Equestrian Center, Inc. to secure medical/surgical treatment and/or hospitalization for the student which they determine necessary or advisable, pending receipt of special consent from the undersigned from any licensed physician to provide including, but not limited to, anesthesia, x-ray, surgery, hospitalization and medication.

Yes, I/my son/daughter would like to participate as a student. I understand that NO LIABILITY can be accepted by any organization concerned with this volunteer service, including Horsefeathers Therapeutic Equestrian Center, Inc., in the event of any accident that may occur.

Student Signature _____ Date _____

Parent/Guardian Signature _____ Date _____
(if student under 18 yrs) _____.

NON-CONSENT

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 Horsefeathers. In the event emergency treatment/aid is required, I wish the following procedure to take place: _____
_____.
_____.

Non-Consent Signature of Student/Parent/Guardian _____

Print Name _____ Date _____

Address _____

PLEASE ATTACH A COPY OF COMPLETE MEDICAL HISTORY