HEROES ON HORSEBACK VETERAN PARTICIPANT REGISTRATION FORM

Phone: 843-757-5607 ♦ Fax: (866) 292-0834

Please note that all paperwork must be received I week prior to the start of each session.

Thank you for your interest in Heroes on Horseback (HOH). The first step toward participating in a HOH program is to complete and return the necessary forms. These forms are valid for one year. If you have current forms on file, then you need only to complete the Continuing Registration Form.

Before a participant can be considered for inclusion in the Heroes on Horseback programs the attached forms must be completed and returned to Heroes on Horseback.

- ➢ Medical history & physician's statement must be completely filled out and signed by the participant's physician
- ➢ Veteran Registration & Authorization for Emergency Medical Treatment to be completed
- ➢ Veteran General Activity and Photo Release

Once all forms are received at Heroes on Horseback, verified for completeness, and reviewed for any contraindications to participation in program activities, the participant will then be scheduled for the upcoming session.

HOH strives to provide the safest possible conditions for participants, volunteers, employees and horses. The acceptance and continued participation of a participant in our program depends on the availability of instructors, volunteers and suitable horses, and is based on our determination that we can safely accommodate the participant. HOH adheres to precautions and contraindications for participants established by PATH, Intl. HOH retains the right to refuse any participant that we cannot safely accommodate. Participants must inform HOH of changes in their health status and an annual update of the Medical History Form and Physician's Form is required.

We thank you for your interest and look forward to serving you soon. Please feel free to contact the office if you have any questions at (843) 757-5607.

Sincerely,

Bob Lee
Executive Director

HEROES ON HORSEBACK

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Veteran Registration and Authorization for Emergency Medical Treatment

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 the agency, I authorize Heroes on Horseback to Secure and retain medical treatment and transportation if needed. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Participant Name:	Phone:	Email:
Address:	City:	State / Zip:
If I cannot be reached Contact:	Phone:	Phone:
Physician's Name:	Phone:	
Preferred Medical Facility:	Health Insurance Company: Policy #:	

Consent Plan

The authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Consent Signature:	Date:
Please Print Name:	Phone #:

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 the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Non-Consent Signature:	Date:
Please Print Name:	Phone #:

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Veteran Medical History & Physicians' Statement

This form to be completed by a medical professional if the current form we have on file is older than 3 years from the start date of the session

Participant Name:	**Date of Birth:**	**Sex:**	**Race:**	**Height**	**Weight:**
Diagnosis:			**Date of Onset:**		
Medications:			**Tetanus Shot:** **YES** **NO** **Date:**		

Please indicate if patient has a problem and/or surgical history in any of the following areas:

AREA	YES	NO	COMMENTS	AREA	YES	NO	COMMENTS
Auditory				Muscular			
Visual				Independent Ambulation			
Speech				Crutches			
Allergies				Braces			
Cardiac				Wheelchair			
Circulatory				Neurological			
Learning Disability				Orthopedic			
Mental Impairment				Pulmonary			
Psychological Impairment				Other			
Seizures			Type:	Controlled:			Date of Last Seizure:

**** Please complete required information on page 2 for SEIZURE patients** **** See Page 2 for list of precautions and contraindications**

I have reviewed the attached list of conditions which may present precautions and contraindications to therapeutic horseback riding on page 2, to my knowledge there is no reason why this person cannot participate in supervised equestrian activities:

Physician's Signature:	**Date of EXAM:**
Physician's Name (please print):	**Physician's Phone:**
Address:	**Physician's FAX:**

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Veteran Medical History & Physicians' Statement
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SEIZURE DISORDER PARTICIPANTS

PATH, recommends the following information for PATH Operating Centers for riders with seizure disorders.
Would you consider _____'s seizures to be:

☐ Completely controlled ☐ Very well controlled ☐ Fairly controlled by medication

Type of seizure:	
Typical aura:	
Typical motor activity during seizure:	
Description of client's behavior during post-ictal state:	Post-ictal state duration:
Specific directions as to what to do if a seizure should occur at Heroes on Horseback:	
Physician's Signature	Date:

INFORMATION FOR PHYSICIAN

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

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

NEUROLOGIC
Hydorcephalus/shunt
Spina bifida
Tethered Cord
Chiarıl Malformation
Hydromyelia
Paralysis due to Spinal Cord
Injury
Seizure Disorders

SECONDARY CONCERNS
Behavior Problems
Age under 2 years
Age 2 - 4 years
Acute exacerbation of chronic
disorder
Indwelling catheter

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

HEROES ON HORSEBACK
Bluffton, South Carolina
Phone (843) 757-5607

VETERAN GENERAL ACTIVITY RELEASE, RISK ASSUMPTION, LIABILITY WAIVER AND PHOTO RELEASE

This document waives important legal rights. Read it carefully before signing.

I **AGREE** that I choose to participate voluntarily in Heroes on Horseback activities as a rider, handler or spectator. I am fully aware and acknowledge that horse sports and Heroes on Horseback activities involve inherent dangerous risks of accident, loss, and serious bodily injury including, but not limited to, broken bones, head injuries, trauma, pain, suffering or death ("Harm"). I fully understand that this release covers, but is not limited to, inherent risks of an equine activity which mean a danger or condition that is an integral part of an equine activity, including but not limited to, any of the following:

- The propensity of an equine to behave in ways that may result in injury, death, or loss to persons on or around the equine;
- The unpredictability of an equine's reaction to sounds, sudden movement, unfamiliar objects, persons, or other animals;
- Hazards, including, but not limited to, surface or subsurface conditions;
- A collision with another equine, another animal, a person, or an object;
- The potential of an equine activity participant to act in a negligent manner that may contribute to injury, death, or loss to the person of the participant or to other persons, including but not limited to, failing to maintain control over an equine or failing to act within the ability of the participant.

I **AGREE** that I would like to participate in the Heroes on Horseback program. I acknowledge the risks and potential risks, however, I feel that the possible benefits to me are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors or administrators waive and release forever all claims for damages against Heroes on Horseback, its Board of Directors, instructors, therapists, aides, volunteers, employees, facility owners, NCM Equestrian LLC and affiliated organizations for any and all injuries and/or losses I may sustain while participating in the Heroes on Horseback program including activities occurring outside of the scope of the program itself, including, but not limited to transportation, care giving, horse exercising etc.

By signing below, I **ACKNOWLEDGE** that I enter into this release after having read the same, and place my signature hereto of my own free voluntary act and deed. By signing below, I represent to Heroes on Horseback that I fully understand its contents, that I do not need any further explanation, and I waive any further explanation.

I **AGREE** to assume all risks of Harm to me and **specifically agree to the SOUTH CAROLINA LIABILITY LAW** regarding equine/ farm animal activity liability: **Under South Carolina Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of equine activity, Pursuant to Article 7, Chapter 9 of Title 47, Code of Laws of South Carolina, 1976.**

ACCEPTED BY:

Participant Signature:	Print Participant Name:	Date:

Photo Release

- ❑ I consent
- ❑ I do not consent

to and authorize the use and reproduction by Heroes on Horseback of any and all photographs and any other audio-visual materials taken of me for the benefit of this program

Date: _____ Signature: _____