HEARTLAND HORSES
EQUINE ACTIVITIES & LEARNING

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Participant Registration Packet

Heartland Horses Equine Activities & Learning, Inc. is a 501c3 non-profit organization which provides Equine Assisted Activities, Interactions, & Riding to significantly improve the lives of children & adults with disabilities & challenges in our surrounding counties ***free*** of charge with a referral from a medical or mental health provider.

(Down Syndrome individuals will also need to complete a Physician Statement confirming cervical vertebrae x-ray results)

In order to participate, ***all*** attached forms must be completed ***annually*** including the medical referral pages & returned to HHEAL to schedule your appointment.

Please plan to arrive 15 minutes prior to your scheduled appointment

Attendance Policy

24 Hour Cancellation Notice required. Three unexcused absences will forfeit your time slot.
Our schedule coincides with the Highlands County School Calendar.

Dress Code

Participants are required to wear enclosed shoes or boots & long pants.
ASTM-SEI approved helmets are mandatory & are supplied.
Sun screen & insect repellent suggested.

Code of Conduct

HHEAL is proud to be a member of PATH (the Professional Association of Therapeutic Horsemanship, Int.).
We are an EAAT Health Facility which prohibits tobacco & vapor use on premises
for the health, wellbeing & safety of our human & horse population.

While HHEAL charges no fees for our services, donations are always welcomed!

Rider Information Form

HHEAL is a 501c3 Non-profit organization that provides equine assisted riding and interaction for children and adults with special needs. In order to participate, please complete all forms. If the rider is a minor or medically unable to sign, a parent or guardian must sign all releases.

PARTICIPANT INFORMATION:

Date: _____ **Date of Birth:** _____ **Age:** _____

Last Name: _____ **First Name**: _____

Sex: Male ☐ Female ☐ **Race:** Caucasian ☐ African American ☐ Hispanic ☐ Other ☐

Primary Phone: _____ **Alternate Phone**: _____

Primary Email: _____

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

County: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ **Relationship**: _____

Phone: _____ **Alternate Phone:** _____

Participant Physician: _____ **Phone:** _____

In case of an emergency, I give permission to Heartland Horses Equine Activities & Learning, Inc. to secure emergency medical treatment for me/my son/my daughter/my ward.

_____ _____ _____

Printed Name Signature Date

LIABILITY RELEASE:

Under Florida Law. An equine activity sponsor or 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 activity.

***Rider Release Statement**:* By signing below 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 Heartland Horses Equine Activities & Learning, Inc., its Board of Directors, Instructors, Volunteers, and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Heartland Horses Equine Activities & Learning, Inc.

_____ _____ _____

Printed Name Signature Date

EQUINE ACTIVITY SPONSOR/PHOTO RELEASE:

I _____ hereby consent ☐ do not consent ☐ to & authorize the use & reproduction by Heartland Horses Equine Activities & Learning, Inc. of any and all photographs and/or video materials taken of me/my son/my daughter/ my ward for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

_____ _____ _____

Printed Name Signature Date

Medical/Mental Health Professional Referral Form

Rider Information Form

Annual Verification

In my opinion, this person can participate in HHEAL programs which are designed to meet the needs of individuals & groups. Lessons are facilitated by PATH certified instructors to inspire growth through interactive & engaging activities with horses; emotionally, cognitively, socially, & physically.

Participant Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Height: _____ Weight: _____ D.O.B.: _____

***In consideration of the fitness of our horses and client safety, riders must not exceed 200 lbs. Overweight participants may do therapeutic ground work, but are not permitted to ride.**

Diagnosis: _____ Date of onset: _____

Seizures: ◯ Yes ◯ No Type: _____ Controlled: _____

Medications: _____

Tetanus Shot: ◯ Yes ◯ No Date Received: _____

Please indicate if patient has a problem in any of the following areas:

Auditory ◯ Yes ◯ No Comments: _____

Visual ◯ Yes ◯ No Comments: _____

Speech ◯ Yes ◯ No Comments: _____

Cardiac ◯ Yes ◯ No Comments: _____

Circulatory ◯ Yes ◯ No Comments: _____

Pulmonary ◯ Yes ◯ No Comments: _____

Neurological ◯ Yes ◯ No Comments: _____

Muscular ◯ Yes ◯ No Comments: _____

Orthopedic ◯ Yes ◯ No Comments: _____

Allergies ◯ Yes ◯ No Comments: _____

Balance ◯ Yes ◯ No Comments: _____

Learning Disabilities ◯ Yes ◯ No Comments: _____

Rider Information Form

Medical/Mental Health Professional Referral Form

The following conditions, if present, may represent precautions or contraindications to horseback riding & interactions. Therefore; when completing this form, please note whether these conditions are present.

Orthopedic:	**Neurological**:	**Medical/Surgical:**
Spinal Fusion	Hydrocephalus/Shunt	Allergies
Spinal Instabilities	Spina Bifida	Cancer
Atlantoaxial Instability	Tethered Cord	Poor Endurance
Scoliosis	Chiari II Malformation	Recent Surgeries
Kyphosis	Hydromyelia	Peripheral Vascular Disease
Hip Subluxation/Dislocation	Spinal Cord Paralysis	Varicose Veins
Osteoporosis	Seizure Disorders	Hemophilia
Pathologic Fracture	Developmental Delay	Hypertension
Coxasarthrosis	Rhetts Syndrome	Cardiac Condition
Heterotopic Ossification	Angelmans Syndrome	Stroke
Cranial Deficits	Seizures/Epilepsy	
Spinal Orthoses		
Internal Spinal Stabilization Devices		

Emotional:

Behavioral	Anxiety	Substance Abuse
Adjustment Disorder	Bipolar	ADD/ADHD
Disruptive Mood Dyseregulation	Depression	Eating Disorder
Dysthymic Disorder	OCD	Poor Impulse Control
PTSD		

Mental Impairment ◯ Yes ◯ No Comments: _____

Psychological Impairment ◯ Yes ◯ No Comments: _____

Mobility: Independent Crutches Walker Wheelchair

Special Precautions: _____

Contagious Disease: _____

Rider Information Form

Physician Approval to Ride

Medical/Mental Health Provider Printed Name: _____

Signature: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date: _____

Annual Physician Statement for Down Syndrome

If a participant has Down Syndrome, an additional Atlantoaxial Dislocation x-ray form is required from a physician.

Participant Name: _____ **Date of Birth:** _____

Address: _____

A cervical vertebrae x-ray study shows that this person (circle one):

***DOES* HAVE** **or** ***DOES NOT* HAVE**

Evidence of Atlantoaxial Instability or Subluxation.

If he/she does have this condition, then participation in horseback riding will not be allowed.

Medical/Mental Health Provider Printed Name: _____

Signature: _____

SAVE FORM

HEARTLAND HORSES EQUINE ACTIVITIES & LEARNING, INC. (HHEAL)

COVID-19 Acknowledgement of Risk and Acceptance of Services*

*Required for ALL individuals participating in HHEAL programs; This includes Client/Participants, parents, guardians, caregivers, employees, volunteers, and visitors. Thank you for your cooperation.

I,_____(Client/Participant and name of Parent or Guardian, if Client/Participant is a Minor), am aware of the risks of contracting Covid-19 while receiving face-to-face services from HHEAL at this time of the pandemic outbreak.

I am also aware that face to face services increase my risk of contracting and passing on the Covid-19 or Coronavirus and agree to hold harmless HHEAL, its employees, volunteers and all other individuals I may come in contact with during this interaction and receiving of services.

I agree to and will follow all guidelines for personal hygiene, personal safety and public safety as recommended by HHEAL and my individual provider/practitioner. This may include, but is not limited to waiting in or near my vehicle until called to ride, washing my hands prior to each session, use of hand sanitizer upon request; wiping down surfaces with disinfecting wipes and/or wearing a protective mask.

I agree to refrain from participating if I have within the previous 24 hours to 2 weeks personally exhibited or have been in contact with someone who has presented with illness including; cough, sneezing, fever, chest congestion or additional signs of potential spread of any virus or bacteria/disease.

HHEAL will engage in regular cleaning and sanitizing of horse tack, grooming supplies and office, doors, and frequently touched areas in-between clients and on a daily basis as recommended by the Center for Disease Control (CDC) and our contracted Veterinarian for the safety of Client/Participants, parents, guardians, caregivers, employees, volunteers and equine animals.

I am signing under my own free will and choice and agree to follow these and hold harmless all individuals associated with or through my services acquired from HHEAL.

DATED:_____, 2020

_____	_____
Client/Participant's Name (Print)	Client/Participant's Name (Signature)
_____	_____
Parent or Legal Guardian's Name (Print)	Parent or Legal Guardian's Name (Signature)
_____	_____
Witness' Name (Print)	Witness' Name (Signature)

SAVE FORM