

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.

(Individuals with Down Syndrome 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.

Our Mission: To significantly improve the lives of individuals who are physically, emotionally, or developmentally challenged.

HHEAL's mission to improve the lives of individuals is valued by our leadership and employees. We are committed to maintaining a diverse, equitable, and inclusive environment for staff, participants and volunteers. We strive to respect life experiences and place value on all individuals as an equal contributor to our overall success. We are committed to providing a respectful and fair atmosphere for all individuals, and fostering a sense of belonging for everyone active in our program.

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

Session Day/Time: __ Tuesday Morning __ Wednesday Morning __ Wednesday Evening __ Thursday Morning
__ Saturday Morning

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

Rider Information Form

Medical/Mental Health Professional Referral 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:

Spinal Fusion

Spinal Instabilities

Atlantoaxial Instability

Scoliosis

Kyphosis

Subluxation/Dislocation

Osteoporosis

Pathologic Fracture

Coxarthrosis

Heterotopic Ossification

Cranial Deficits

Spinal Orthoses

Internal Spinal Stabilization Devices

Emotional:

Behavioral

Adjustment Disorder

Disruptive Mood Dysregulation

Dysthymic Disorder

PTSD

Mental Impairment () Yes () No Comments: _____

Psychological Impairment () Yes () No Comments: _____

Mobility: Independent Crutches Walker Wheelchair

Special Precautions: _____

Contagious Disease: _____

Neurological:

Hydrocephalus/Shunt

Spina Bifida

Tethered Cord

Chiari II Malformation

Hydromyelia

Spinal Cord Paralysis

Seizure Disorders

Developmental Delay

Rhetts Syndrome

Angelmans Syndrome

Seizures/Epilepsy

Medical/Surgical:

Allergies

Cancer

Poor Endurance

Recent Surgeries

Peripheral Vascular Disease Hip

Varicose Veins

Hemophilia

Hypertension

Cardiac Condition

Stroke

Rider Information Form

Physician Approval to Participate in Equine Activities

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: _____