HIS MOUNTAINTOP MINISTRIES

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Rider's Registration and Release Form

Participant/Rider_____ DOB: _____ Age: _____

Address: _____

Phone: _____ Work #: _____ Emergency #: _____

Parent/Legal Guardian/Caregivers: _____

Address (if different from above): _____

Phone: _____

School or Institution Presently Attending: _____

Physician's Name:_____ Address: _____ Phone#: _____

Disability: _____

In case of Emergency: Contact:_____ Phone#: _____

Contact:_____ Phone#: _____

Personal Medical Conditions

It is your responsibility to check with a medical doctor to see if you (or your ward) have any medical or physical conditions which would preclude or limit your participation in this activity or create a risk to yourself, your ward, or others who would depend on you during this activity. These conditions may include, but are not limited to, the following: Physical or medical disabilities, medication or drugs being taken, dietary restrictions, allergies or sensitivities to penicillin, insects, bees, poison oak, horses, dust, food, etc. You should discuss any potential problems with His Mountaintop Ministries staff and the volunteer assigned prior to participating.

Obligation Regarding Own Medical Insurance

No personal medical insurance is provided by His Mountaintop Ministries -Therapeutic/Adaptive Horsemanship for you or your ward for participating in His Mountaintop Ministries activities. It is your responsibility to obtain proper personal medical and injury insurance for you or your ward.

Participation In This Activity Is Voluntary

If you feel a particular part of the activity is beyond you or your ward's ability or you feel it has some risks that you or your ward are not prepared to accept, you should not participate in that aspect of the activity. It is your responsibility, however to constantly evaluate His Mountaintop Ministries Therapeutic/Adaptive Horsemanship's activities and you and your ward's ability to safely participate in such and make careful decisions whether or not to participate. Participation is at you and your ward's own risk.

General Risks

Please understand that participating in His Mountaintop Ministries - Therapeutic/Adaptive Horsemanship activities, depending on the activity, may be risking the participant's/rider's physical being. It is impossible to list all the dangers involved in any activity. The eventualities of injuries, death, or property damage are so diverse that no one can anticipate or guard against everything that can go wrong. Before you consent to your or your participant's/rider's participation, you should become informed as much as possible about the inherent dangers associated with the particular activities in which you, he or she is going to be engaged. You should also make sure that you or your participant/rider is adequately prepared with the proper skills, knowledge, equipment, and clothing to minimize these dangers.

Liability Release

For His Mountaintop Ministries - Therapeutic/Adaptive Horsemanship permitting me (or my ward) to participate in the above stated activity, I understand and agree that situations may arise during the event which may go beyond the control of His Mountaintop Ministries, its volunteers or other program participants.

FOR MYSELF, MY WARD AND OUR PERSONAL REPRESENTATIVES, ASSIGNEES, HEIRS AND NEXT OF KIN, OR ANY OF THEM, I AGREE TO RELEASE, FOREVER DISCHARGE AND NOT TO SUE HIS MOUNTAINTOP MINISTRIES, ITS DIRECTORS, OFFICERS, EMPLOYEES, VOLUNTEERS AND AGENTS AND EACH OF THEM (COLLECTIVELY, "RELEASEES") FROM ANY AND ALL CLAIMS AND LIABILITY FOR ANY INJURY, LOSS, LIABILITY, DAMAGES OR FEES, COSTS, EXPENSES (COLLECTIVELY, THE "CLAIMS") HOWSOEVER SUFFERED OR INCURRED ARISING OUT OF OR IN ANY WAY CONNECTION WITH MY OR MY WARD'S PARTICIPATION IN HIS MOUNTAINTOP MINISTRIES ACTIVITIES, ON ACCOUNT OF ANY INJURY TO MY PERSON OR PROPERTY OR MY DEATH ARISING OUT OF OR IN ANY WAY CONNECTED WITH MY PARTICPATION IN ANY OF THE ACTIVITIES, WHETHER CAUSED BY ACTIVE OR PASSIVE NEGLIGENCE OF RELEASEES OR OTHERWISE, BUT EXCLUDING THE SOLE ACTIVE NEGLIGENCE OF RELEASEES. I AGREE TO DEFEND AND INDEMNIFY RELEASEES AND EACH OF THEM FROM ANY LOSS, LIABILITY, DAMAGE OR COSTS THEY OR ANY OF THEM MAY INCUR DUE TO INJURY TO ME OR MY PROPERTY OR TO MY DEATH RESULTING FROM MY USE OF THE FACILITIES OR MY PARTICIPATION IN ANY ONE OR MORE OF THE ACTIVITIES. EXCLUDING THAT CAUSED BY THE SOLE ACTIVE NEGLIGENCE OF RELEASEES. Initial_____

If I (or my ward) file suit, it will be in Placer County, CA. and if the suit is unsuccessful, I agree to pay court cost and attorney fees for the defendants. I HEREBY WAIVE ALL SUCH CLAIMS WHICH I NOW OR MAY HEREAFTER HAVE AGAINST THE ABOVE ENTITIES. I have read and understand the above and agree to be bound by it. Initial_____

Assumption of Risks

By signing and/or initialing as appropriate you are agreeing to the following:

I have read the above statement of risks and I acknowledge that I am fully aware of and acquainted with the dangers and risks of the activity, and that I (or my ward) am the appropriate skill level and physical condition to undertake the rigors of the activity. If I (or my ward) have any doubts of my physical or mental condition, we will seek medical advice. I have made a careful decision that I am willing to and hereby do accept and assume all risks for myself and my ward of the activity. Initial_____

I ASSUME ALL RISK OF INJURY, DEATH OR PROPERTY DAMAGE RESULTING FROM MY OR MY WARD'S PARTICIPATION IN ANY OF THE ACTIVITIES.

Important Note

BEFORE SIGNING, READ CAREFULLY THIS PAPER. DO NOT ENROLL YOURSELF OR YOUR CHILD UNTIL YOU FULLY UNDERSTAND THIS STATEMENT AND THE RISKS ASSOCIATED WITH THIS ACCTIVITY. IF YOU HAVE ANY QUESTINS, PLEASE DO NOT HESITATE TO ASK A STAFF MEMBER AT (530) 561-4321.

I, ON MY OWN BEHALF (OR THAT OF MY WARD), HAVE READ CAREFULLY THIS FORM AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY, A WAIVER OF CLAIMS, AN AGREEMENT NOT TO SUE, A CONTRACT BETWEEN ME AND HIS MOUNTAINTOP MINISTRIES, AND FOR THE BENEFIT OF ME AND OTHERS DESCRIBED HEREIN. I SIGN IT OF MY OWN FREE WILL.

_____ Date:_____

Parent/Guardian

_____ Date:_____

Rider/Participant/Ward (if over the age of 18)

HIS MOUNTAINTOP MINISTRIES

PATH INTERNATIONAL
Professional Association of TheraPeutic Horsemanship International

Partkipant s Applicatnon and licalth History

GENERAL INFORMATION

Participant: _____

D(,B: _____ Age: ____ Height: _____ Gender: M F

Address: _____

Phone: _____ Email: _____ Alternative #: _____

Employer/School: _____

Address: _____

Phone _____

Parent/Legal Guardian/Caregivers _____

Address (if different from above): _____

Phone _____

Referral Source: _____

Phone: _____

How did you hear about the program? _____

HEALTH HISTORY

Diagnosis _____ Date of Onset _____

Please indicate current or past special needs in the following areas

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

(over)

MEDICATIONS (include prescription, over-the-counter,: name, does, and frequency)

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed)

PHYSICAL FUNCTION (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

PSYCHO/SOCIAL FUNCTION (i.e. Work/school including grade completed, leisure interest, relationships family structure, support systems, companion animals, fears/concerns, etc.)

GOALS (i.e. Why are you applying for participation? What would you like to accomplish?)

Signature _____ Date _____

PHOTO RELEASE

I ☐ DO
☐ DO NOT
consent to and authorize the use and reproduction by
of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Information for Physician

In order to safely provide this service, our center requests that you complete/update this Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contradictions to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlanto-axial Instability – w/clinical neurological symptoms
Cervical Arthritis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint Subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizures
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other
Age under 4 years
Indwelling Catheter/Medical Equipment
Medications – sedative/drowsiness
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbation of medical conditions (i.e. RA, MS)
Fire Seizures
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/phone indicated.

His Mountaintop Ministries - Therapeutic/Adaptive Horsemanship
P.O.BOX 578
Lincoln, CA 95648
email: horsesdoctor@ymail.com
www.hismountaintopministries.com
Office: 530-561-4321 Cell: 530-218-5479

HIS MOUNTAINTOP MINISTRIES

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Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____
Address: _____
Diagnosis: _____ Date of Onset: _____
Past/Prospective Surgeries: _____
Medications: _____
Seizure Type: _____ Controlled: Y N Date Last Seizure: _____
Shunt Present: Y N Date of Last Revision: _____
Special Precautions/Needs: _____
_____
Mobility: Independent Ambulation Y N Assisted Ambulation . Y N Wheelchair Y N
Braces/Assistive Devices: _____
For those with Down Syndrome: AtlantoDens Interval X-Rays, date: _____ Result: + --
Neurological Systems of AtlantoAxial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
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, this person is not medically precluded from equine assisted activities. I understand that the PATH will weigh the medical information given against existing precautions and contradictions. Therefore, I refer this person to the PATH center, H.M.M. Therapeutic/Adaptive Horsemanship, for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other: _____
Signature: _____ Date: _____
Address: _____
Phone: ( )_____ License/UPIN Number: _____

Please see other side →

HIS MOUNTAINTOP MINISTRIES

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Authorization for Emergency Medical Treatment

☐ Participant ☐ Staff ☐ Volunteer

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to Medications: _____

Current Medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

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 the agency. I authorize _____ to

(Center Name)

1. Secure and retain medical treatment and transportation if needed
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: _____ Consent Signature: _____

Client, Parent or Legal Guardian

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.

☐ Parent or legal guardian will remain on site at all times during equine assisted activities

☐ In the event of emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

_____

Date: _____ Non-Consent Signature: _____

Client, Parent or Legal Guardian

HIS MOUNTAINTOP MINISTRIES

Physical Therapy Assessment

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NAME: _____ DIAGNOSIS: _____

AGE: _____ SCHOOL/CLINIC: _____

EVALUATION SUMMARY:

Describe the riding candidate's current functional level. Indicate...

☐ Degree of trunk/head control:

☐ Any lower extremity or adductor tightness:

☐ Presence of any contractures (indicate location):

☐ Degree and/or type of assist for transfers or mobility

○ Weight-bearing ○ Partial-weight-bearing ○ Full Transfer

☐ Any weakness or issues with muscle tone:

☐ Other

PRECAUTIONS AND/OR RESTRICTIONS:

SUGGESTED EXERCISES AND/OR STRETCHES:

SIGNATURE: DATE:

HIS MOUNTAINTOP MINISTRIES

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

HIS MOUNTAINTOP MINISTRIES, INC

Therapeutic/Adaptive Horsesmanship

We're not disabled, we're just different

* *ATTENTION * * * PLEASE READ CAREFULLY * * * ATTENTION * *

There will be an immediate termination of Riding Privileges and/or Property Privileges, if any one or a combination of any listed offenses, including but not inclusive to:

NO Smoking anywhere in riding or barn areas at any time
NO Alcohol anywhere in riding or barn areas at any time
NO drugs anywhere in riding or barn areas at any time
No speeding in open area before parking or leaving property
Swearing or Foul Language
Breaking the Confidentiality agreement
Abusing Volunteer or Horses verbally or Physically (Hitting, Spitting, Biting or Kicking, etc.)
Speaking to a staff member, Volunteer, Parent or Client in a disrespectful or derogatory manner
Any damage to property or Program equipment, Program Director, Property owner and any local law enforcement agency will be notified

Signed_____ Date_____

P.O.BOX 578 Lincoln, CA 95648 email: horsesdoctor@ymail.com www.hismountaintopministries.com