MARION THERAPEUTIC RIDING ASSOCIATION, INC.
6850 SE 41st Court, Ocala, FL 34480
Phone (352)732-7300
information@mtraocala.org

Participant and Health History Forms

(PLEASE PRINT)

Participant's Name:________________________________ Current date:____________________
Date of Birth: _______________ Male/Female: ____ *Age: ____ **Weight: ____ Height: ______
☐ Parent or ☐Legal Guardian Name: ____
Address: ____________________________City: ___________ State: ___ Zip: ________
Home #: _______________________ Work # (list owner): ____________________________
Cell#/Mom: __________________ Cell#/Dad ___________________ Cell #/Guardian:_________________
E-mail address: ____

**Riders must be at least four years of age.*
***A rider's maximum weight may not exceed 200 lbs. This limitation assures the wellness and optimum soundness of MTRA horses, ensures properly fitted equipment is available, and provides a safe environment for staff, volunteers, and participants. Participants over the maximum weight are encouraged to participate in un-mounted activities such as groundwork or Equine Facilitated Learning lessons.*

For grant purposes, please complete the following:	Indicate one:
Family Gross Income Level: (select one) $ 9,000 to 15,000 ____ $15,001 to 24,000 ____ $24,001 to 45,600 ____ $45,601 and up ____	1) White American ____ 2) Black _____ 3) Native American ____ 4) Hispanic ____ 5) Native Hawaiian or Other Pacific Islander ___ 5) Other (list heritage) ____________________
Receive government financial assistance: Yes____ No ____	Family size: ______ Veteran: Yes ____ No ____ Female Head of Household: Yes ___ No___

REQUIRED INFORMATION

Participant's Disability:____
Date of Onset (when did symptoms begin): __________________________________

HEALTH HISTORY (REQUIRED):

Parent/Legal Guardian please list ***current*** or ***past*** physical, emotional, and/or mental conditions that require consideration when the participant is engaging in ***any*** equine related activity. This includes, but is not limited to riding and other equine assisted activities. **BE SPECIFIC**. Examples include: limited or no vision in right eye; brace on left ankle; uncontrollable outburst of anger; fear of heights, animals, and/or horses; allergic reaction to dust and/or animal dander; onset of seizure indicator (such as heat); rods in back; and shunts in use. If no current or past conditions apply, please write NA.

NOTE: Regardless of your physician's permission/release, the final decision for participation in therapeutic riding and/or equine related activities rests with MTRA's Program Director.

Revised: March 2015

MEDICAL INFORMATION:

Physician's Name: ____

Physician's Address: ___________________________ **Phone:** _______________

Health Care Insurance Company: __________________ **Policy No:** _____________

MEDICATIONS:

What medications is the Participant currently taking? This does includes over the counter medications.
NOTE: Be sure to let us know when medications are added or changed.

____

____

____

AMULATORY STATUS:

Can the Participant walk without any assistance? If no, does he or she use crutches, braces, walker or a wheelchair? Please describe:

____

EMERGENCY CONTACT:

Person who is authorized to give temporary assistance or care in absence of parent or legal guardian:

NAME: ____

PHONE # ____________________ **RELATIONSHIP** ______________________________

Medical conditions requiring special precautions or treatment. Please check one:
(A) None _______ **(B)** Yes, please describe below________:

____

____

EMERGENCY MEDICAL RELEASE:

In case of a **Medical Emergency**, I ___________________________________ (Client, Parent, or Legal Guardian) authorize **Marion Therapeutic Riding Association, Inc.** to provide such medical assistance as they determine to be necessary.

In the event that the **physician listed above cannot be reached**, I ______________________________ (Client, Parent, or Legal Guardian) authorize any medical care, surgical care, and/or hospital staff to provide care, which includes anesthetic, for the participant which they determine necessary or advisable.

No rider can be accepted for riding instruction until this form has been completed by the Parent/Parents or Legal Guardian/Legal Guardians. **IF** the participant is of legal age (18), he or she may complete the form **IF** he or she is legally competent to do so.

Yes, I would like ___________________________________ to have riding instruction, and I have discussed this with his or her doctor.

SIGNATURE OF Parent OR Legal Guardian: ____________________________________

PRINT NAME OF Parent OR Guardian: _______________________________________

!!WARNING!!
UNDER FLORIDA LAW, AN EQUINE ACIVITY 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 ACTIVITIES. FL STATUTE #773.01

LIABILITY RELEASE AGREEMENT

The undersigned acknowledges that the handling of horses is hazardous to the horse handler, rider and horse, and therefore, willingly and knowingly, accepts whatever risks are involved with riding and/or handling horses under the instruction of **Marion Therapeutic Riding Association, Inc.** The undersigned hereby releases Marion Therapeutic Riding Association, Inc., and/or Hillcrest School and Marion County School Board and/or the state of Florida Department of Environmental Protection, Office of Greenways and Trails, and the state of Florida from all liabilities arising out of any occurrence which results in injury, loss and/or damage to the volunteer, personnel, horse and/or equipment. Additionally, the undersigned prohibits any relative, representative, and/or agent from seeking relieve for any damages from Marion Therapeutic Riding Association, Inc., and/or Hillcrest School and Marion County School Board and/or the state of Florida Department of Environmental Protection, Office of Greenways and Trails, and the state of Florida on behalf of the undersigned.

Signature: ____ **Date:** ________________
(Volunteer, Client, Parent or Guardian)

Signature: ____ **Date:** ________________
(Parent/Guardian for Volunteer under age of 18)

PHOTO RELEASE

I ☐ DO

authorize and consent to the use and reproduction by **Marion Therapeutic Riding Association, Inc.** of any and all photographs and any other audiovisual materials taken of me for promotional printed material, educational activities, or for any other use for the benefit of **Marion Therapeutic Riding Association, Inc.**

Signature: ______________________________ **Date:**_______________
(Volunteer, Client, Parent or Guardian)

Signature: ______________________________ **Date:**_______________
(Parent/Guardian for Volunteer under age 18)

I ☐ DO NOT

authorize and consent to the use and reproduction by **Marion Therapeutic Riding Association, Inc.** of any and all photographs and any other audiovisual materials taken of me for promotional printed material, educational activities, or for any other use for the benefit of **Marion Therapeutic Riding Association, Inc.**

Signature: ______________________________ **Date:**_______________
(Volunteer, Client, Parent or Guardian)

Signature: ______________________________ **Date:**_______________
(Parent/Guardian for Volunteer under age 18)

Describe your abilities/difficulties in the following areas (include assistance or equipment required):
PHYSICAL FUNCTION (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

____
____
____

PSYCHO/SOCIAL FUNCTION (e.g.,. work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

____
____
____

GOALS (i.e. why would you like to participate? What would you like to accomplish?

____
____
____

I certify the above information is correct to the best of my knowledge

Signature: _____________________________________ Date: ______________________
Client (or Parent or Legal Guardian if client is under 18)

CONFIDENTIALITY POLICY

I understand that any personal or identifying information that I learn about clients through my association with Marion Therapeutic Riding Association will remain confidential. I agree to refrain from discussing such details as: clients' names, specific diagnosis, unusual behavior, etc., with anyone outside the program or with another program member in a public circumstance where I might be overheard. I understand the necessity of preserving our clients' privacy and anonymity and will abide by this agreement.

Signature: ____________________________________Date: ___________________
Client (or Parent or Legal Guardian if client is under 18)

MTRA BILLING INFORMATION SHEET	
Student's First and Last Name:	
Bill to (Full Name):	
Street Address:	
City, State, Zip:	
Phone:	
Email*:	

Cancellation Policy

Horses are very expensive to maintain and we depend on income from our lessons to keep the program going! In order to effectively manage paid staff and volunteer hours, MTRA must enforce the following cancellation policy:

- **A credit will only be given when MTRA cancels a class.**
- We are aware some of our clients have special health issues which may cause the rider to miss a session. **MTRA will allow one excused absence per session**. If the rider misses more than one class they are responsible for paying for that class.
- No rider will be able to start a new session if they have a past due balance from the previous session. Anyone who has a past due balance should contact the Executive Director to make payment arrangements. Any rider who has not made payment arrangements from a past due bill will not be allowed to ride.
- If a rider misses 2 lessons without notifying MTRA, They may be removed from the schedule for that session. The rider may apply to re-enter the program for the following schedule but is not guaranteed a spot.

Thank you for your cooperation!!

I understand I will be billed for any services provided to the above student(s) and I agree to pay for these services.

Signature: ____ Date: ______________

*Providing an email address allows MTRA to send you statements electronically. Your email address will be used solely to facilitate electronic billing and communications with MTRA. You will be able to view and pay your statement online by credit card at the website indicated on the statement. You will also be able to pay by mailing a check or providing cash/check to the MTRA staff. If the entire session is paid in advance of the session, you will receive a 10% discount. MTRA knows this may be a hardship for some and is willing to take weekly payments if needed.

Rider's Medical History and Physician's Statement
(To be completed annually)

Safety Issues and Limitations:

The safety of all riders, horses and staff is very important during MTRA's riding classes and horse related activities. An individual's unique weight/height/balance ratio plays an integral part in determining his/her ability to safely ride or drive an equine. Regardless of other conditions and/or limitations, the MTRA's Program Director can prohibit a student from participating in horse related activities.

Physical Exam Considerations:

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

Orthopedic

Atlantoaxial Instability
Scoliosis
Kyphosis
Lordosis
Joint Subluxation and Dislocation
Osteoporosis
Patholgic Fractures
Coxas Arthrosis
Heterotopic Ossification
Myositis Ossificans
Osteogenesis Imperfecta
Cranial Deficits
Spinal Joint Abnormalities
Spinal Joint Fusion/Fixation
Spinal Joint Instability

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Exacerbations of medical conditions
Dangerous to self or others
Fire Settings
Hemophilia
Medical Instability
Migraines
Diabetes
Respiratory Compromise
Recent Surgeries
Substance Abuse
Weight Control Disorders
Separation Anxiety

Neurologic

Hydrocephalus/shunt
Spina Bifida
Tethered Cord
Cranial Malformation
Hydromyelia
Seizure Disorder
Chiari II Malformation

Other Concerns

Behavior problems
Age under four years
Indwelling catheter
Poor Endurance
Skin Breakdown
External Medical Devices

Although all riders are required to obtain a medical release from their physician, the final decision regarding the contraindication of any medical condition rests with MTRA's Program Director. If, in the opinion of the Program Director, there is an unacceptable possibility of injury should the rider experience a fall or sudden change of gait the rider will be prohibited from participation.

Rider's Medical History and Physician's Statement

Name: ____ Date of Birth: _________________________

Name of Parent/Guardian: ____

Address: ____

Height _________ Weight ___________

Diagnosis: ____ Date of Onset: _____________________

PATH International requires that all participants with Down Syndrome have:

A. A yearly medical examination including a complete neurologic exam that shows no evidence of atlantoaxial Instability (AAI).
B. Certification by a physician that an examination did not reveal atlantoaxial instability or focal neurologic disorder.

Tetanus Shot: _____ yes _____ no Date: _________________

Seizure Type _________________ Controlled _____________ Date of last seizure _____________________

Medications: ____

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			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Skin			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Balance			
Emotional/Psychological			
Pain			
Other			

Mobility: Independent Ambulation: _____ Yes _____ No Crutches: _____ Yes _____No
Braces: _____Yes _____ No Wheelchair: _____ Yes _____ No

Please indicate any special precautions: ____

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against existing precautions and contraindications. Therefore, I refer this person to the riding center for ongoing evaluation to determine eligibility for participation.

Physician Name (please print) ____

Physician Signature ____

Address ______________________________________ City _______________________ State ____ Zip _____________

Phone ______________________________________ Date: ____________________________