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

[redacted]

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:	**$ 9,000 to 15,000 ____**	**1) White American ____ 2) Black _____**
(select one)	**$15,001 to 24,000 ____**	**3) Native American ____ 4) Hispanic ____**
	$24,001 to 45,600 ____	**5) Native Hawaiian or Other Pacific Islander ___**
	$45,601 and up ____	**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: May 2013

MEDICAL INFORMATION:

Physician's Name: _____

Physician's Address: _____ Phone #: _____

Health Care Insurance Company: _____ Policy #: _____

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: _____

PLEASE READ AND SIGN BOTH SECTIONS

!!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**
☐ **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)

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: _____