2022-23

NOTE: Must be updated ANNUALLY but continuing riders may use the update form

New Participant's Application & Health History

GENERAL INFORMATION

NOTE: 185 lb. Weight limit!

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: ☐ M ☐ F

Address: _____

Phone: _____ E-mail: _____ 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, dose 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 interests, 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 Turning Point Ranch
(center)

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: _____

Client, Parent or Legal Guardian

Signed in the presence of center staff

2022-2023

Authorization for Emergency Medical Treatment Form

Participant 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: _____

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 **Turning Point Ranch Therapeutic Riding Center** to:

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.

Consent Plan

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, Caregiver or Legal Guardian
Signed in presence of center staff

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM

2022-2023

(Completed by Physician)

TURNING POINT
Horses Building Futures

Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: ____ Weight: _____

Address: _____ NOTE: 185 lb. weigh limit!

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of 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: + -

Neurologic Symptoms of Atlanto Axial 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 participation in equine assisted activities and/or therapies. I understand that the PATH Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____

2022-2023

TURNING POINT
Horses Building Futures

RIDER/PARTICIPANT RELEASE OF LIABILITY FORM

The undersigned _____, of lawful age, represents that he/she is the parent or legal guardian of _____, a minor child, who is a rider/participant in the TURNING POINT RANCH THERAPEUTIC HORSEBACK RIDING PROGRAM.

He/She hereby acknowledges the inherent, foreseeable, and unforeseeable risks and/or perils associated with horses, activities involving such animals, and the facilities wherein such activities are conducted.

In recognition thereof, and for and in consideration of the opportunity for said minor child to ride/participate in the TURNING POINT RANCH THERAPEUTIC HORSEBACK RIDING PROGRAM, the undersigned does hereby for and on behalf of said minor child and his/her heirs, executors, administrators, successors and assigns, release, acquit, waive, hold harmless, and forever discharge TURNING POINT RANCH THERAPEUTIC RIDING CENTER and its directors, employees, volunteers, landlords/landowners and/or agents, from any and all liability, claims, losses, actions, suits, causes of action, demands, rights, damages, costs, expenses, fees and/or compensation of any type, description or character whatsoever, which may accrue on account of said minor child's participation as a rider/participant in the TURNING POINT RANCH THERAPEUTIC HORSEBACK RIDING PROGRAM.

By executing this agreement, it is his/her intention to fully assume, on behalf of said minor child, all risk of bodily injury, death, or property damage occurring as a result of said minor child's participation as a rider in the TURNING POINT RANCH THERAPEUTIC HORSEBACK RIDING PROGRAM. He/She further agrees to indemnify and hold harmless TURNING POINT RANCH THERAPEUTIC RIDING CENTER and its directors, employees, volunteers, landlords/landowners and/or agents, from any and all liability, claims, losses, actions, suits, causes of action, demands, rights, damages, costs, expenses, fees and/or compensation of any type, description or character whatsoever, which may accrue on account of the actions, intentional, negligent, or otherwise, of said minor child, himself/herself, or his/her guest, while participating in the TURNING POINT RANCH THERAPEUTIC HORSEBACK RIDING PROGRAM, or while present on the premises used for said program and related activities.

I acknowledge that I have read the foregoing agreement and fully understand its content.

_____ _____

Signature Date

2022-2023

TURNING POINT
Horses Building Futures

Participant's Consent for Release of Information

I hereby authorize: Stillwater Public Schools and/or Physician
(person or facility)

to release information from the records of:

_____ DOB: _____
(participant's name)

The information is to be released to: Turning Point Ranch Therapeutic Riding Center
(center name)

for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

- Medical history
- Physical therapy evaluation, assessment and program plan
- Speech therapy evaluation, assessment and program plan
- Mental health diagnosis and treatment plan
- Individual Habilitation Plan (I.H.P.)
- Classroom Individual Education Plan (I.E.P.)
- Psychosocial evaluation, assessment and program plan
- Cognitive-behavioral management plan
- Other: _____

This form shall remain in effect as long as the student participates at Turning Point unelss revoked in writing by me.

Signature: _____ Date: _____

Print Name: _____

Relation to Participant: _____

Please send materials to:

Turning Point Ranch
385 S Country Club
Stillwater, OK 74074