Office use only:

Photo Release Y / N
Medical Consent Y / N

Cloud Dancers Therapeutic Horsemanship Program, Inc.

2018 Participant Application

Participant's Name: ______________________ DOB: ____________ Today's Date: ________________

Address (street) ________________ (city) ____________ (state) ______ (zip) ________ Phone: ________________

Parent/Guardian's Name: ________________ Phones: (H) __________ (C) ____________ (W) ____________

Email: ______________________

Please complete the following summary. Describe the participant's 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)*

____

____

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

____

____

OTHER THERAPIES (*Has the participant ever received any type of therapy such as Physical Therapy, Speech-Language Therapy, or Occupational Therapy? If yes, indicate which one(s) and when received.)*

____

GOALS *(What would the participant/family/guardian(s) like to accomplish through this program?)* ______________________________

____

Please indicate availability:

___ Weekday ___ Morning

___ Weekend ___ Afternoon

___ Evening

How will you pay for lessons? (*check all that apply)*:

___ Private

___ Scholarship (*i.e. CTHF)*: ______________________

___ DD Waiver/Medicaid (i.e. Mi Via, Centennial Care): ______________

___ Other ______________________

Cloud Dancers Therapeutic Horsemanship Program, Inc.

Authorization for Emergency Medical Treatment Form

Participant's Name: ____________________ Physician's Name: ____________________

Preferred Medical Facility: ____________________ Health Insurance Company: __________ Policy #: __________

Allergies: ______________________________

Current medications: ____

IN THE EVENT OF AN EMERGENCY, CONTACT:

Name: ______________ Relationship: ________ Phone: ________

Name: ______________ Relationship: ________ Phone: ________

Name: ______________ Relationship: ________ Phone: ________

PARENT/LEGAL GUARDIAN (*if applicable*):

Name: ______________ Address: (street) ____________ (city) ________ (state) ___ (zip) _____ Phone: ________

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, while being on the property where the riding program operates, or in participating in other program activities, I authorize Cloud Dancers Therapeutic Horsemanship Program, Inc. 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.***

Select <u>one</u> of the plans below:

CONSENT Plan	NON-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. Consent name (printed): ____________________ Individual or Parent/Legal Guardian Consent name Signature: ____________________ Date: __________	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 where the riding program operates. * Parent or legal guardian will remain on site at all times during equine assisted activities. * In the event emergency treatment/aid is required, I wish the following procedures to take place: ____ ____ Non-Consent name (printed): ____________________ Individual or Parent/Legal Guardian Non-Consent name Signature: ____________________ *Signed in presence of center staff* Date: __________

Participant Liability and Photo Release Form

Liability Release (required)

The undersigned, a participant, or the undersigned, as parent(s) or guardian(s) of ______________________, a participant, for and in consideration of the agreement of Cloud Dancers Therapeutic Horsemanship Program, Inc. to provide equine assisted activities to said participant, does/do hereby forever release, acquit, discharge and hold harmless Cloud Dancers Therapeutic Horsemanship Program, Inc., its officers, trustees, agents, employees, representatives, staff, volunteers, successors and assigns, for all manner of claims, demands and damages of every kind and nature whatsoever, which the undersigned or said rider may now, or in the future, have against Cloud Dancers Therapeutic Horsemanship Program, Inc., its officers, trustees, agents, employees, representatives, staff, volunteers, successors and assigns on account of any personal injuries, physical or mental condition, known or unknown, to the person of said rider and the treatment therefore as a result of, or in any way growing out of, the acts of Cloud Dancers Therapeutic Horsemanship Program, Inc., its officers, trustees, agents, employees, representatives, staff, volunteers, successors and assigns, including, but not limited to, their negligence or gross negligence, in rendering the services above described or in any way incidental thereto.

Individual or Parent/Legal Guardian (print name): ________________________________ **Signature**: __________________________________ **Date**: ___________

Photo/Media Release (optional)

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grant to Cloud Dancers Therapeutic Horsemanship Program, Inc., permission to take or have taken, still or moving photographs and films including television picture of ____________________, a participant, of Cloud Dancers Therapeutic Horsemanship Program, Inc. I/we further consent and authorize Cloud Dancers Therapeutic Horsemanship Program, Inc., its advertising agencies, news media, and any other persons interested in Cloud Dancers Therapeutic Horsemanship Program, Inc., and its work, to use and reproduce the photographs, films and pictures to circulate and publicize the same by all means including without the generality of the foregoing newspapers, web site, television media, brochures, pamphlets, instructional materials, books, and clinical material. With regard to the foregoing material, no inducements or promises have been made to us/me to secure our/my signature(s) on this release other than the intention of Cloud Dancers Therapeutic Horsemanship Program, Inc. to use or be used such photographs, films and pictures for the primary purpose of promoting and aiding Cloud Dancers Therapeutic Horsemanship Program, Inc., and its work. I/we understand that this permission is not restricted to the duration of time the above named participant is a registered participant in a Cloud Dancers Therapeutic Horsemanship Program. I/we further understand that I/we can reverse this permission at any time by submitting a written statement to that effect to Cloud Dancers Therapeutic Horsemanship Program, Inc., P.O. Box 14089, Albuquerque, NM 87191.

Individual or Parent/Legal Guardian (printed name): ______________________________ **Signature**: ___________________________________ **Date**: ___________