HEARTLAND HORSES
EQUINE ACTIVITIES & LEARNING

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Participant Registration Packet

Heartland Horses Equine Activities & Learning, Inc. is a 501c3 non-profit organization which provides Equine Assisted Activities, Interactions, & Riding to significantly improve the lives of children & adults with disabilities & challenges in our surrounding counties ***free*** of charge with a referral from a medical or mental health provider.

(Down Syndrome individuals will also need to complete a Physician Statement confirming cervical vertebrae x-ray results)

In order to participate, ***all*** attached forms must be completed ***annually*** including the medical referral pages & returned to HHEAL to schedule your appointment.

Please plan to arrive 15 minutes prior to your scheduled appointment

Attendance Policy

24 Hour Cancellation Notice required. Three unexcused absences will forfeit your time slot.
Our schedule coincides with the Highlands County School Calendar.

Dress Code

Participants are required to wear enclosed shoes or boots & long pants.
ASTM-SEI approved helmets are mandatory & are supplied.
Sun screen & insect repellent suggested.

Code of Conduct

HHEAL is proud to be a member of PATH (the Professional Association of Therapeutic Horsemanship, Int.).
We are an EAAT Health Facility which prohibits tobacco & vapor use on premises
for the health, wellbeing & safety of our human & horse population.

While HHEAL charges no fees for our services, donations are always welcomed!
We receive no funding from local, state, or federal government.

Rider Information Form

HHEAL is a 501c3 Non-profit organization that provides equine assisted riding and interaction for children and adults with special needs. In order to participate, please complete all forms. If the rider is a minor or medically unable to sign, a parent or guardian must sign all releases.

PARTICIPANT INFORMATION:

Date: _____ **Date of Birth:** _____ **Age:** _____

Last Name: _____ **First Name**:_____

Sex: Male___ Female___ **Race:** Caucasian _____ African American_____ Hispanic_____ Other _____

Primary Phone: _____ **Alternate Phone**: _____

Primary Email: _____

Mailing Address: _____**City**:_____**Zip**:_____

County: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ **Relationship**:_____

Phone: _____ **Alternate Phone:** _____

Participant Physician: _____ **Phone:** _____

In case of an emergency, I give permission to Heartland Horses Equine Activities & Learning, Inc. to secure emergency medical treatment for me/my son/my daughter/my ward.

_____ _____ _____

Printed Name Signature Date

EQUINE ACTIVITY SPONSOR/PHOTO RELEASE:

I_____ hereby consent____ do not consent ____ to & authorize the use & reproduction by Heartland Horses Equine Activities & Learning, Inc. of any and all photographs and/or video materials taken of me/my son/my daughter/ my ward for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Under Florida Law. An equine activity 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 activity.

***Rider Release Statement**:* By signing below I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Heartland Horses Equine Activities & Learning, Inc., it's Board of Directors, Instructors, Volunteers, and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Heartland Horses Equine Activities & Learning, Inc.

_____ _____ _____

Printed Name Signature Date

Rider Information Form

Medical/Mental Health Professional Referral Form

Annual Verification

In my opinion, this person can participate in HHEAL programs which are designed to meet the needs of individuals & groups. Lessons are facilitated by PATH certified instructors to inspire growth through interactive & engaging activities with horses; emotionally, cognitively, socially, & physically.

Participant Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Height: _____ Weight: _____ D.O.B.: _____

Diagnosis:_____ Date of onset: _____

Seizures: ( )Yes ( ) No Type: _____ Controlled: _____

Medications: _____

Tetanus Shot: ( ) Yes ( ) No Date Received: _____

Please indicate if patient has a problem in any of the following areas:

Auditory ( ) Yes ( ) No Comments: _____

Visual ( ) Yes ( ) No Comments: _____

Speech ( ) Yes ( )No Comments: _____

Cardiac ( )Yes ( )No Comments: _____

Circulatory ( )Yes ( )No Comments: _____

Pulmonary ( )Yes ( ) No Comments: _____

Neurological ( ) Yes ( ) No Comments: _____

Muscular ( )Yes ( )No Comments: _____

Orthopedic ( ) Yes ( ) No Comments: _____

Allergies ( ) Yes ( ) No Comments: _____

Balance ( ) Yes ( ) No Comments: _____

Learning Disabilities ( ) Yes ( ) No Comments: _____

Rider Information Form

Medical/Mental Health Professional Referral Form

The following conditions, if present, may represent precautions or contraindications to horseback riding & interactions. Therefore; when completing this form, please note whether these conditions are present.

Orthopedic:	**Neurological**:	**Medical/Surgical:**
Spinal Fusion	Hydrocephalus/Shunt	Allergies
Spinal Instabilities	Spina Bifida	Cancer
Atlantoaxial Instability	Tethered Cord	Poor Endurance
Scoliosis	Chiari II Malformation	Recent Surgeries
Kyphosis	Hydromyelia	Peripheral Vascular Disease
Hip Subluxation/Dislocation	Spinal Cord Paralysis	Varicose Veins
Osteoporosis	Seizure Disorders	Hemophilia
Pathologic Fracture	Developmental Delay	Hypertension
Coxasarthrosis	Rhetts Syndrome	Cardiac Condition
Heterotopic Ossification	Angelmans Syndrome	Stroke
Cranial Deficits	Seizures/Epilepsy	
Spinal Orthoses		
Internal Spinal Stabilization Devices		

Emotional:

Behavioral	Anxiety	Substance Abuse
Adjustment Disorder	Bipolar	ADD/ADHD
Disruptive Mood Dyseregulation	Depression	Eating Disorder
Dysthymic Disorder	OCD	Poor Impulse Control
PTSD		

Mental Impairment ( ) Yes ( ) No Comments: _____

Psychological Impairment ( ) Yes ( )No Comments: _____

Mobility: Independent Crutches Walker Wheelchair

Special Precautions: _____

Contagious Disease: _____

Rider Information Form

Annual Physician Statement for Down Syndrome

If a participant has Down Syndrome an additional Atlantoaxial Dislocation x-ray form is required from a physician.

Participant Name: _____ **Date of Birth:** _____

Address: _____

A cervical vertebrae x-ray study shows that this person (circle one):

***DOES* HAVE** **or** ***DOES NOT* HAVE**

Evidence of Atlantoaxial Instability or Subluxation.

If he/she does have this condition, then participation in horseback riding will not be allowed.

Medical/Mental Health Provider Printed Name: _____

Signature: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date: _____