HEARTLAND HORSES
EQUINE ACTIVITIES & LEARNING
4305 Independence Street
Avon Park, FL 33825
www.Heartlandhorses.org
Heartlandhorsesflorida@gmail.com
(863) 452-0006

Participant Registration

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

In order to participate, all attached forms must be completed, including the medical professional (physician, mental health provider, case worker pages) &, returned to HHEAL to schedule your appointment.

(All forms are to be updated annually.)

(Down Syndrome individuals will also need to complete a Physician Statement confirming cervical vertebree x-ray results; issued upon request.)

Our Six Week Summer Program begins June 5, 2017.
Sessions are approximately 30 minutes in duration & are scheduled Monday –Thursday From 8am – 9:30am.

Participants will need to wear closed toe shoes or boots & long pants.
Helmets are mandatory & are supplied.

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

We want to serve you better! Please tell us!
What can HHEAL & its programs do for this registered participant to enhance their quality of life?

_____

_____

Welcome to HHEAL!
Where the possibilities are endless far beyond our gates!

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Heartland Horses Equine Activities & Learning, Inc. - 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 _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

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

County: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ **Relationship:** _____

Home Phone: _____ **Cell 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 and authorize the use and 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

Heartland Horses Equine Activities & Learning, Inc. – Medical Professional Information Form

To be completed by physician annually.

Physician 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: _____

Heartland Horses Equine Activities & Learning, Inc. – Medical Professional Information Form

To be completed by physician annually.

Information for Physician:

The following conditions, if present, may represent precautions or contraindications to horseback riding & interaction. 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: _____

Heartland Horses Equine Activities & Learning, Inc.

Annual Physician Statement Form for Down Syndrome

To be completed by physician annually.

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** 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.

Physician Printed Name: _____

Physician Signature: _____

Address: _____

City: _____ State: _____ Zip: _____

Date: _____ Phone: _____

Physician Phone: _____