HORSE WARRIORS™

Box 602 • Jackson • WY • 83001 (307) 733-7464; CELL: (307) 690-6124

Authorization for Emergency Medical Treatment Form

❑ Participant ❑ Staff ❑ Volunteer

Name: _____ DOB: _____ Phone: _____

Mailing Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Consent Plan

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 HORSE WARRIORS™ 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.

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 or Legal Guardian

Non-Consent Plan

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 of the agency.

- ❑ 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 procedure to take place:

_____

_____

_____

Date: _____ Non-Consent Signature: _____

Client, Parent or Legal Guardian

Participant's Application & Health History

GENERAL INFORMATION

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			

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 HORSE WARRIORS™ 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

P.O. Box 602 • Jackson • Wyoming • 83001

P.O. Box 1331 • Thayne • WY • 83127

PHONE: (307) 733-7464

CELL: (307) 690-6124

Waiver, Consent and Liability Release

This document contains important information about your rights. Please read it carefully. If you do not understand it, we encourage you to consult with an attorney regarding its meaning. If you do not understand it, do not sign it.

In agreeing to voluntarily participate in **Horse Warriors/CIREQUUS™** activities, and in signing this document, you are acknowledging that there are dangers or conditions that are characteristic of, intrinsic to, and an integral part of horseback riding and any other equine activity.

I acknowledge and understand that when I take part in horseback riding or other equine activity as part of my participation in **Horse Warriors/CIREQUUS™**, I assume the inherent risks in that activity, whether those risks are known or unknown. I acknowledge and understand that I am legally responsible for any and all damage, injury or death to myself or other persons or property that result from the inherent risks of the activity. I also understand that **Horse Warriors/CIREQUUS™** is not required to eliminate, alter or control the inherent risks of horseback riding or other equine activities.

_____

Participant

_____

Date

_____

Parent (if participant is a minor)