



STUDENT APPLICATION FORM

This form must be completed in full and original
returned to GREAT for participation.

(NO FAXED COPIES WILL BE ACCEPTED)

GREENWOOD EQUINE ASSISTED THERAPIES, INC.
351 Jordan Street Shreveport, La 71101 (318) 938-9166

DATE _____
NAME _____ BIRTH DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME NUMBER (_____) _____ WORK NUMBER (_____) _____

SCHOOL OR OTHER EDUCATIONAL INSTITUTION ATTENDING _____

DIAGNOSIS _____ WEIGHT _____ HEIGHT _____

IF UNDER AGE 18 NAME OF PARENT/GUARDIAN _____

WORK PLACE _____ WORK PHONE _____

IN CASE OF EMERGENCY NOTIFY _____ HOME PHONE _____

RELATIONSHIP _____ WORK PHONE _____

ADDRESS _____

PRIMARY CARE PHYSICIAN _____ PHONE NUMBER _____

HOSPITAL AND TOWN PREFERRED _____

I AM/MY CHILD IS: AMBULATORY _____ NON-AMBULATORY _____ VERBAL _____ NON-VERBAL _____

I USE/MY CHILD USES: WHEELCHAIR _____ CRUTCHES _____ BRACES _____ OTHER _____

I/MY CHILD CAN _____ CANNOT _____ SIT INDEPENDENTLY

I WOULD LIKE TO APPLY FOR A SCHOLARSHIP: YES _____ NO _____

IN CASE OF EMERGENCY, I GIVE PERMISSION TO GREENWOOD EQUINE ASSISTED THERAPIES, INC. TO
SECURE MEDICAL TREATMENT INCLUDING X-RAY, SURGERY, HOSPITALIZATION AND MEDICATION.

STUDENT SIGNATURE OR IF UNDER 18, PARENT/GUARDIAN SIGNATURE _____ DATE _____

MAKE CHECKS PAYABLE TO: GREAT OR GREENWOOD EQUINE ASSISTED THERAPIES

FOR OFFICE USE ONLY

DATE APPLICATION RECEIVED _____

DATE STUDENT BEGAN RIDING _____

RIDER AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

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 Greenwood Equine Assisted Therapies, Inc. to:

1. Secure and retain medical treatment and transportation needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Client's Name _____ Phone _____

Address _____

In the event I can not be reached contact _____

Phone _____

contact _____ Phone _____

Physician's Name _____

Preferred Medical Facility _____

Health Insurance Co. _____ Policy # _____

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 below is unable to be reached.

Date _____ Consent Signature _____

Client, Parent or Guardian

Print Name _____ Phone _____

Address _____

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. In the event emergency treatment/aid is required, I wish the following procedures take place:

Date _____ Non-Consent Signature _____

Client, Parent or Guardian

Print Name _____ Phone _____

Address _____

STUDENT LIABILITY RELEASE

I, the undersigned adult student, or parent or guardian of _____, a minor student, would like to participate at Greenwood Equine Assisted Therapies, Inc. (hereinafter referred to as GREAT). I acknowledge the risks and potential for risks of horseback riding. I understand that I/my son/daughter/ward, will be working with and around horses, as well as riding horses of GREAT; however I feel that the possible benefits to myself/son/daughter/ward are greater than the risk assumed. I, the undersigned student and or parent/guardian, hereby intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and forever release, acquit, discharge and hold harmless all claims for damages against GREAT, its board of directors, trustees, agents, instructors, therapists, employees, representatives, successors, assigns, volunteers, owners of the property on which GREAT operates, for any and all manner of claims, demands and damages of every kind or nature whatsoever, which student may now, or in the future have against GREAT, its board of directors, trustees, agents, instructors, therapists, employees, representatives, successors, assigns, volunteers, owners of the property on which GREAT operates, successors or assigns on account of any personal injuries and/or personal damages known or unknown, or in any way growing out of, the acts of GREAT, its board of directors, trustees, agents, instructors, therapists, employees, representatives, successors, assigns, volunteers, owners of the property on which GREAT operates successors or assigns.

I understand that Greenwood Equine Assisted Therapies, Inc. is a "FARM ANIMAL SPONSOR WITHIN THE MEANING OF LOUISIANA REVISED STATUTE SECTION 9:2795.1, WHICH PROVIDES:

UNDER LOUISIANA LAW, A FARM ANIMAL ACTIVITY SPONSOR OR FARM ANIMAL PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR DEATH OF A PARTICIPANT IN FARM ANIMAL ACTIVITIES RESULTING FROM THE INHERENT RISKS OF FARM ANIMAL ACTIVITIES, PURSUANT TO R.S. 9:2795.1.

Student Signature

Date

If under 18 years, Parent of Guardian Signature

Date

PHOTO RELEASE

For valuable consideration given, which is hereby acknowledged, the undersigned hereby grants to Greenwood Equine Assisted Therapies, Inc. (hereinafter referred to as GREAT), permission to take or have taken still and moving photographs and films including television pictures of (name) _____ and consents and authorizes GREAT, its advertising agencies, news media, and any other person interested in GREAT and its work, to use and reproduce the photographs, films and pictures and to circulate and publicize the same by all means including, but not limited to, newspapers, television media, brochures, pamphlets, instruction material, books and clinical material.

With respect to the foregoing matters, no inducements or promises have been made to us/me to secure our/my signatures to this release other than the intention of GREAT to use or cause to be used such photographs, films and pictures for the primary purpose of promoting and aiding GREAT and its work.

Student signature or if under 18 years, Parent or Guardian Signature

Date

NON-CONSENT

I do not give my consent to Greenwood Equine assisted Therapies, Inc. to take or have taken still and/or moving photographs and films including television pictures

Student signature or if under 18 years, Parent or Guardian Signature

Date

RIDERS MEDICAL HISTORY AND PHYSICIANS STATEMENT FORM

To be completed annually

(PLEASE CHECK WHERE APPLICABLE)

Name _____ Date of Birth _____

Address _____

Name of Parent/Guardian _____

Diagnosis _____ Date of Onset _____

****FOR PERSONS WITH DOWN SYNDROME: (BOTH MUST BE CHECKED BY PHYSICIAN AND X-RAY DATE PROVIDED OR STUDENT WILL NOT BE ABLE TO PARTICIPATE)**

Negative Cervical X-ray for Atlantoaxial Instability. X-ray Date _____

Negative for clinical symptoms of Atlantoaxial Instability.

Tetnus Shot Yes No Height _____ Weight _____

Seizure Type _____ Controlled _____ Date of last seizure _____

Medications _____

*Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

*Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent ambulation Yes No Crutches Yes No Braces Yes No
 Wheelchair Yes No Please indicate any special precautions _____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician's Name _____ Date _____

Physician's Signature _____

Address _____ Phone _____

INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Medical/Surgical

Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident)

Secondary Concerns

Behavior Problems
Age under two years
Age two – four years
Acute exacerbation of chronic disorder
Indwelling catheter

Neurologic

Hydrocephalus/Shunt
Spina Bifida/Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis due to Spinal Cord injury
Seizure Disorders