

Equine Magic Therapeutic Services

At Horizon Stables
730 Rubright Road
Apollo, PA. 15613



Lisa Schartiger, MPT
670 Carnahan Road
Avonmore, PA. 15618

Participant's Application and Health History

To be completed by the participant, or parent/ guardian

GENERAL INFORMATION:

Participant's name: _____
Date of birth: _____ Age: _____ Height: _____ Weight : _____ M F
Address: _____
Phone: _____ Alternative: _____
Employer/School: _____
Address: _____
Phone: _____
Parent/Legal Guardian: _____
Address (if different from above) _____
Phone: _____
Referral Source: _____
Contact Numbers: _____
How did you hear about the program? _____

HEALTH HISTORY

Please indicate current or past problems in the following areas:

	Y/N	Comments
Vision.....		
Hearing.....		
Sensation.....		
Communication.....		
Heart.....		
Breathing.....		
Digestion.....		
Elimination.....		
Circulation.....		
Emotional.....		
Behavioral.....		
Pain.....		
Bone/Joint.....		
Muscular.....		
Thinking/Cognition.....		
Allergies.....		

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What medications are you currently taking, including over the counter medications? _____

Describe your abilities/difficulties in the following areas, include assistance required or equipment needed:

FUNCTION: (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

SOCIAL: (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?)

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CLIENT LIABILITY RELEASE

I/my child would like to participate in the Equine Magic Therapeutic Services (EMTS) program. I acknowledge the risks and the potential for risks of engaging in horseback riding activities as well as activities in close proximity to horses. However, I feel that the possible benefits to me/my child are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors and/or administrators, waive and release forever all claims for damages against EMTS, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses that I/my child may sustain while participation in activities at EMTS.

Print Name: _____ Date _____

Caregiver/Client/Legal guardian consent signature _____

UNDER PENNSYLVANIA LAW – AN 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 ACTIVITIES.

PHOTO RELEASE

I consent to authorize the use and reproduction by EMTS 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