Dear Participant:

We invite you to experience the joys of equine-assisted activities and therapies at **The Horses Helping Heroes Project.** This program is generously funded by private donations, fundraising efforts and the local business community. All services provided by this program are **FREE OF CHARGE** to all active duty military and military and first responder veterans.

The Horses Helping Heroes Project is a 501(c)(3) non-profit organization dedicated to providing equine-assisted activities to veterans challenged with a variety of special needs or disabilities. We bring together a team of skilled horses and a group of dedicated, fully-trained local volunteers to teach you the foundations of horsemanship and equine behavior. **The Horses Helping Heroes Project** is located outside of Smithfield at a private facility.

Through **The Horses Helping Heroes Project**, our PATH-certified instructors, assisted by our trained volunteers, will help you learn a variety of equestrian skills which can improve balance, fine motor skills, speech and perceptual skills, build muscle strength and self-confidence and improve focus. We also offer a full lunch at the end of each class to our participants and onsite volunteers.

If you would like to enroll in a session, please complete the following forms and return them to the address indicated below:

Participant Application and Health History
Participant's Medical History and Physician's Release
Authorization for Emergency Medical Treatment
Consent/Non-Consent for Media Release
Release, Waiver & Indemnity Agreement (to be completed onsite, the first day of class)

For more information, please contact Debi Demick at (757) 356-0408. We look forward to seeing you at the barn.

Sincerely,

The Staff at the **Horses Helping Heroes Project**

1807 S. Church Street, Suite 108, PMB 143, Smithfield, VA 23430

PARTICIPANT APPLICATION AND HEALTH HISTORY

Name: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____

Phone: _____ Alternative: _____

Email address: _____

Employer: _____

Health History

Primary diagnosis: _____ Date of onset: _____

Secondary diagnosis: _____ Date of onset: _____

Please indicate current or past special needs in the following areas:

Special Needs	**Y**	**N**	**Comments**
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

Medications (*including prescription, over the counter, name, dose and frequency)*:

_____

_____

_____

_____

(Form continues on next page)

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

Physical Function: (Mobility skills such as transfers, walking, wheelchair use, driving/bus riding):

Psycho/Social Function: (Work, including family structure, relationships, support systems, companion animals, leisure interests, fears/concerns, etc.)

Goals: (What would you like to accomplish?)

How did you hear about the program?

Signature: _____ **Date**: _____

Participant's Medical History and Physician's Release – Must be completed by physician

Name:_____DOB:_____Height:_____Weight _____

Address: _____

Primary Diagnosis: _____ Date of Onset: _____

Secondary Diagnosis _____ Date of Onset: _____

Tertiary Diagnosis _____ Date of Onset: _____

Shunt Present: Y/N Date of Last Revision: _____Tetanus shot: Y/N: Date if Yes _____

Seizure Type: _____ Controlled: Y/N Date of last seizure: _____

PLEASE LIST ALL CURRENT MEDICATIONS:

1. _____ taken for _____
2. _____ taken for _____
3. _____ taken for _____

Any contagious diseases:_____

Please indicate if a patient has a problem and/or surgeries in any of the following areas. If yes, please comment, using the back of the form if necessary.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disabilities			
Mental Impairment			
Psychological Impairment			
Incontinence			
Coordination			
Balance			

Mobility: Independent Ambulation: Yes _____ No _____ Crutches: Yes _____ No _____
Wheelchair: Yes _____ No _____ Braces: Yes _____ No _____

Past/Prospective Surgeries:_____

Special Precautions/Needs:_____

Physician's signature required on next page

Physician Information

The following conditions, if present, may represent precautions and contraindications to therapeutic horseback riding. Please be sure to clearly identify and check the boxes if any of the following conditions are present and explain to what degree.

Orthopedic		**Medical/ Surgical**	
Spinal Fusion		Allergies	
Spinal Instabilities/ Abnormalities		Cancer	
Internal Spinal Stabilization Devices		Poor Endurance	
Atlantoaxial Instabilities		Recent Surgery	
Scoliosis s		Diabete	
Kyphosis		Peripheral Vascular Disease	
Lordosis		Varicose Veins	
Hip Subluxation and Dislocation		Hemophilia	
Osteoporosis		Hypertension	
Pathologic Fractures		Serious Heart Condition	
Coxas Arthrosis		Stroke (Cerebrovascular Accident)	
Heterotopic Ossifaction			
Osteogenesis Imperfecta			
Cranial Deficits			
Spinal Orthoses			
		Neurologic	
Secondary Concerns		Seizure disorders	
Behavior problems		Hydrocephalus/shunt	
Acute exacerbation of chronic disorder		Hydromyelia	
Indwelling catheter		Chiari II Malformation	
Integumentary/Skin		Paralysis due to Spinal Cord Injury	

Physician Verification – Please PRINT your name, sign and date. THANK YOU

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the center personnel will weigh the medical information above against the existing precautions and contraindications.

Physician Name/Title: (please print) _____

Signature: _____ **Date;** _____ **Phone:** _____

Address: _____

AdditionalComments_____

_____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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, _____ *(print name)*, hereby authorize **The HORSES HELPING HEROES Project** to:

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

Name: _____ DOB: _____ Age: _____
Address: _____
City/State/Zip: _____ Phone: _____

IN THE EVENT I AM UNCONSCIOUS AND UNABLE TO ACT FOR MYSELF, CONTACT

Name: _____
Relationship: _____ Phone: _____
Physician's Name: _____ Phone: _____
Preferred Medical Facility: _____ Phone: _____
Health Insurance Co.: _____ Policy #_____

In an effort to provide the best care possible, please indicate below if any of the following apply:

☐ I am allergic to the following _____

☐ I have the following ongoing medical conditions: _____

_____

☐ I have been treated recently for the following physical / mental condition: _____

_____

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.

Consent Signature: _____ Date: _____
(Participant/Volunteer)
Print Name: _____ Phone: _____

NON-CONSENT PLAN

I, _____, do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services at The HORSES HELPING HEROES Project. I fully release the center and/or its representatives for any injuries/losses I may incur as a result of this non-consent. In the event emergency aid/treatment is required, I wish the following procedures to take place: _____

_____

Non-Consent Signature: _____ Date: _____
(Participant/Volunteer)
Print Name: _____ Phone: _____

Consent for Media Release

I hereby consent to and authorize the use and reproduction by The HORSES HELPING HEROES Project of any and all photographs and any other audiovisual materials taken of me for promotional printed material, educational activities, publication on The HORSES HELPING HEROES Project web site (www.horseshelpingheroesproject.com) or for any other use for the benefit of the program.

Signature: _____ Date: _____
(Participant/Volunteer)

Non-Consent for Media Release

For reasons that I am not obliged to disclose, I DO NOT give consent for photographs, either still or moving, or any television or news media, to be taken of myself _____, by The HORSES HELPING HEROES Project or any persons working on behalf of said center. I understand that a RED DOT will be placed on the record kept in the administration offices of the center which will designate that photographs are not allowed of said person.

Signature: _____ Date: _____
(Participant/Volunteer)