Christine's Dream

Participant's Application & Health History

General Information

Participant: ____

DOB: _________________ Age: _________ Height: _________ Weight: _________ Gender: M F

Address: ____

Parent(s)/Legal Guardian(s):____

Address (if different from above):____

Phone: (H) _________________________ (C) _________________________ (W) _________________________

Email: ____

Health History (to be completed by participant or parent/legal guardian)

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 and over –the-counter, name, dose and frequency):

____
____
____

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

PHYSICAL FUNCTION (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding):

____
____
____
____
____

PSYCHOSOCIAL FUNCTION (e.g., work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.):

____
____
____
____
____

I understand that the information provided above is accurate to the best of my knowledge.

Signature: ____ Date: ________________

Participant or Parent/Legal Guardian

Photo Release

I ☐ DO

☐ DO NOT

consent to and authorize the use and reproduction by Christine's Dream and Canopy 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: _________________

Participant or Parent/Legal Guardian

Christine's Dream
Participant's Medical History & Physician's Statement

(To be completed by Health Care Provider)

Participant: ______________________________ DOB: ____________ Height: _______ Weight: _______
Address: ____
Diagnosis: ____ Date of Onset: _____________________
Past/Prospective Surgeries: ____
Medications: ____
Seizure Type: ________________________ Controlled: Y N Date of Last Seizure: _______________
Shunt Present: Y N Date of Last Revision: ____
Special Precautions/Needs: ____
____
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices: ____

For those with Down syndrome: Neurologic Symptoms of Atlantoaxial Instability: ☐ Present ☐ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that the PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

Name/Title: ___________________________________ MD DO NP PA Other_________________
Signature: ___________________________________ Date: ________________________________
Address: ____
Phone: ( ) ________________________ License/UPIN Number: ____________________________

Christine's Dream
Authorization for Emergency Medical Treatment Form/ Liability Release

☐Participant ☐Staff ☐Volunteer

Name: ____ DOB: ______________ Phone: _________________________________

Physician's Name: __________________________________ Preferred Medical Facility:_______________________________________

Health Insurance Company: ____ Policy#: _______________________________________

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 **Christine's Dream and Canopy** 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-rays, 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: ____

Volunteer, Staff, Parent, Caregiver 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 Christine's Dream.

☐ Parent or guardian will remain on site at all times during equine assisted activities.

Date: ___________________ Non-Consent Signature: ____

Volunteer, Staff, Parent, Caregiver or Legal Guardian

Liability Release

_________________________________ would like to participate in the Christine's Dream equine activities program. I acknowledge the risks and potential risks of horseback riding and of driving horses or ponies. **Under the Equine Activity Liability Act, each participant who engages in an equine activity expressly assumes the risks of engaging in and legal responsibility for injury, loss, or damage to person or property resulting from the risks of equine activities. Under Illinois law, an equine activity sponsor or professional shall not be liable for any injury to, or the death of a participant in equine activities resulting from the inherent risk of equine activities. I acknowledge the risks and potential for risks of horseback riding and related equine activities involving equines and/or farm animals.** However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs, and assigned executors or administrators, waive and release forever all claims and damages against Canopy, Giant Steps, their board of directors, instructors, therapists, aides, volunteers, boarding facilities, boarders, and/or property owners, and/or employees for any and all injuries which I/my son/my daughter/my ward may sustain while participating in the Christine's Dream equine activities program.

Date: ___________________________ Consent Signature: ____

Volunteer, Staff, Parent, Caregiver or Legal Guardian

Christine’s Dream
Release and Hold Harmless Agreement

WHEREAS, the UNDERSIGNED acknowledges the inherent risks involved in riding and working around horses, these risks include bodily injury from using, riding or being in close proximity to horses, among other risks, and further, that both horses and rider can be injured in normal use or in competition and schooling.

IN CONSIDERATION, therefore, for the privilege of riding and/or working around horses at Christine’s Dream, the undersigned does hereby agree to hold harmless and indemnify Giant Steps and further release them from any liability or responsibility for accident, damage, injury, or illness to the Undersigned or any horse owned by the Undersigned or to any family member or spectator accompanying the Undersigned while on the premises and that except in the event of this stables gross and willful negligence, I shall bring no claims, demands, actions and causes of action, and/or litigation, against this stable for any economic and non-economic losses due to bodily injury, death, and/or property damage sustained by me and/or my minor child or legal ward in relation to the premises and operations of this stable, including while riding, hauling, lessons, adopting horses, shows, activities, trailering, etc.

Date: ______________________________

Signature: _______________________________________

Signature of Parent or Guardian: ____________________________________

Print Name: ______________________________________

Address: ____

Witness Signature: ____

Witness Print Name: _______________________________________