



# HOPE REIGNS RANCH

*Horses Helping People Heal & Grow!!*

•8019 McGregor Road • Rockford, IL 61102 • Phone: 815-262-6008 • Fax: 815-961-1129

## PARTICIPANT PACKET – PLEASE COMPLETE ALL PAGES

### PARTICIPANT INFORMATION

Participant's Full Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Parent(s)/Guardian: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Physician/Therapist Who Referred You: \_\_\_\_\_  
Phone: \_\_\_\_\_

### HEALTH INSURANCE INFORMATION

*Copies of insurance cards are NOT required unless Physical Therapy or Hippotherapy services are available.*

PRIMARY Insured Employer: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Primary Insurance Company: \_\_\_\_\_  
Group#: \_\_\_\_\_ Policy#: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
SECONDARY Insured Employer: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Secondary Insurance Company: \_\_\_\_\_  
Group#: \_\_\_\_\_ Policy#: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered, unless other arrangements have been made. I have read all the information and have completed the above form. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or any of the above information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Signed by Parent/Guardian of participant if under 18 years of age)

# PARTICIPANT EMERGENCY MEDICAL TREATMENT AUTHORIZATION

## 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 Hope Reigns Ranch to:

- 1. Secure and retain medical treatment and transportation if needed.**
- 2. Release patient information/records to the authorized individual agency involved in the emergency medical treatment of the patient.**

Participant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Patient's Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Preferred Medical Facility: \_\_\_\_\_  
Health Insurance Provider: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**The authorization as indicated above 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 listed below is unable to be reached.**

Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signed by participant or parent/guardian if under 18 years of age)  
Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip

## NON-CONSENT PLAN

I **DO NOT** give my consent for emergency aid/treatment in the case of illness or injury during the process of receiving services or while being on the property of Hope Reigns Ranch. In the event emergency aid is required, I wish the following procedures to take place:

\_\_\_\_\_  
\_\_\_\_\_

NON-Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signed by participant or parent/guardian if under 18 years of age)  
Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip

# PHYSICIAN'S MEDICAL RELEASE FORM

Patient/Participant Name: \_\_\_\_\_

**Important Information for Physician:** The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing the "Participant's Medical History and Physician's Annual Statement," 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.

**Neurologic:** Hydrocephalus/shunt, Spina Bifida, Tethered Cord, Chiari II Malformation, Hydromyelia, Paralysis due to Spinal Cord injury, Seizure Disorders.

**Medical/ Surgical:** Allergies, Cancer, Poor Endurance, Recent Surgery, Diabetes, Peripheral Vascular Disease, Varicose Veins, Hemophilia, Hypertension, Serious Hearing Condition, Stroke (Cerebrovascular Accident).

**Secondary Concerns:** Behavior Problems, age under two years, age two-four years, acute exacerbation of chronic disorder, indwelling catheter.

## MEDICAL RELEASE FOR THERAPEUTIC HORSEBACK RIDING

To my knowledge, there is no medical reason why \_\_\_\_\_ cannot participate in supervised therapeutic equestrian activities.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PRESCRIPTION FOR THERAPEUTIC HORSEBACK RIDING

Indicate where appropriate, the need for evaluation and/or treatment by a Physical, Occupational, and/or Speech Therapist in conjunction with therapeutic horseback riding.

Recommended frequency of therapy: \_\_\_\_\_

Precautions, if any: \_\_\_\_\_

\_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PLEASE TYPE OR STAMP THE FOLLOWING:

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

Office Phone: \_\_\_\_\_

Office Fax: \_\_\_\_\_

**NOTE THAT THIS MEDICAL RELEASE FORM CONSISTS OF 2 PAGES.  
Please continue to next page. Physician must complete and sign both pages.**

**PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT**

Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: Male Female

Address: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

*For those with Down's syndrome: AtlantoDens Interval X-Rays Date: \_\_\_\_\_ Result: + -*

**Neurologic Symptoms Of AtlantoAxial Instability:** \_\_\_\_\_

Tetanus Shot: Y N Date: \_\_\_\_\_ Shunt Present: Y N Date of Last Revision: \_\_\_\_\_

Seizure Type: \_\_\_\_\_ Controlled: \_\_\_\_\_ Date Of Last Seizure: \_\_\_\_\_

Medications: \_\_\_\_\_

Mobility: **Independent Ambulation Y N**      **Assisted Ambulation Y N**      **Wheelchair Y N**

Braces/Assistive Devices: \_\_\_\_\_

*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
<b>Auditory</b>			
<b>Visual</b>			
<b>Tactile Sensation</b>			
<b>Speech</b>			
<b>Cardiac</b>			
<b>Integumentary Skin</b>			
<b>Immunity</b>			
<b>Pulmonary</b>			
<b>Neurologic</b>			
<b>Muscular</b>			
<b>Balance</b>			
<b>Orthopedic</b>			
<b>Allergies</b>			
<b>Learning Disability</b>			
<b>Cognitive</b>			
<b>Emotional/Psychological</b>			
<b>Pain</b>			
<b>Other</b>			

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

Name / Title: \_\_\_\_\_ MD DO

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_