HOPE REIGNS RANCH

Horses Helping People Heal & Grow!!

•5201 Safford Rd. • Rockford, IL 61103 • Phone: 815-299-4673

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 o f 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
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Integumentary Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			

Cognitive			
Emotional/Psychological			
Pain			
Other			

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:_____