***Shaw Farms Equine & Therapeutic Center (“SFETC”)***

***47002 Watson Road, St Clairsville OH, 43950***

***7402960067*** [***sfetc2017@gmail.com***](mailto:sfetc2017@gmail.com) ***www.shawfarmsequinetherapeuticcenter.com***

***2023***

***“Lift Me Up”***

SFETC is a nonprofit 501(c) (3) organization located in St. Clairsville, Ohio. Our mission at “SFETC” is to improve the quality of life of children aged 4-20 with developmental/ physical disabilities with the help of our equine assisted activities. Our goal is to provide an atmosphere for learning, healing and growing with the aid of a horse. Each student will have individual attention to help reach his or her greatest potential through the interaction of the horse. To achieve these positive benefits, participants will proceed through the program according to their own ability. This unique connection between horse and rider opens up new directions of growth, change, and recovery for our participants.

2023 SESSION SCHEDULE~ Please circle the monthly session that you would like to attend. You may circle all that work with in your schedule.

May 8-13 June 5-10 July 10-15 August 21-26 September 25-30

Your individual day/time will be released one week prior to upcoming session upon your confirmation of attendance/return of completed /signed paperwork ☺

There is **no** charge to the participant to attend a “Lift Me Up” session.

Please complete/sign/return all **original** paperwork to: SFETC, 47002 Watson Road, St. Clairsville, OH, 43950

\*\*\*\*\*Please make a copy of all paperwork for your records\*\*\*\*

~EQUINE ACTIVITIES PARTICIPANT REGISTRATION

~PHOTE CONSENT/RELEASE

~SFETC LIABILITY WAIVER (please print one per attending person)

~ SEIZURE EVALUATION FORM

~MEDICAL HISTORY & PHYSICIAN STATEMENT

~PARTICIPANT ASSESSMENT & GOAL ASSESSMENT

~ELIGIBILTY CRITERIA AND SFETC’S HOUSE RULES

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SHAW FARMS EQUINE & THERAPEUTIC CENTER (SFETC)

47002 WATSON RD, ST. CLAIRSVILLE OH 43950

7402960067 [sfetc2017@gmail.com](mailto:sfetc2017@gmail.com)

www.shawfarmsequinetherapeuticcenter.com

2023 SFETC Equine Activities Participant Registration

DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participant INFORMATION**

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

Last Name First Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Contact Phone Number

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

City State Zip Code

Sex: F \_\_\_\_\_\_ M \_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Weight\_\_\_\_\_\_ Height \_\_-\_\_**

Has client previously participated in any equine activities? \_\_\_\_\_\_\_\_\_\_

If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant is a *(circle one)*: Adult w/a legal guardian Independent adult

**GUARDIAN & EMERGENCY CONTACT INFORMATION:**

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

Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact? Yes or No

Primary (Preferred) Phone Number Alternate Phone

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

Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact? Yes or No

Primary (Preferred) Phone Number Alternate Phone

Does the Client have **LIFE THREATENING ALLERGIES** (meds, bee stings, latex, etc.): Yes \_\_\_\_\_ No \_\_\_\_\_\_

If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SFETC PHOTO CONSENT**

I hereby consent to and authorize SFETC the use/production of any and all photographs and any other audiovisual materials taken of me, my son or daughter or my ward for promotional printed materials, Facebook page, website, educational activities or for any other use for the benefit of **SHAW FARMS EQUINE & THERAPEUTIC CENTER.**

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

Signature Relationship to Rider Date

I hereby **DO NOT** consent to allow SFETC the use of any photographs or any other audiovisual materials taken of me, my son or daughter or my ward for promotional printed materials,

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

Signature Relationship to Rider Date

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**SHAW FARMS EQUINE & THERAPEUTIC CENTER “SFETC”**

**WAIVER OF LIABILITY AND CONSENT FOR INDIVIDUALS TO PARTICIPATE**

**IN SHAW FARMS EQUINE & THERAPEUTIC CENTER PROGRAMS**

I hereby grant consent for the undersigned Equine Activity Participant (as such term is defined in Ohio Revised Code 2305.321, Section A(3) and referred herein as “Participant”) to participate in the **SHAW FARMS EQUINE & THERAPEUTIC CENTER.** In addition, this document constitutes a written Waiver of Liability, as defined and described in Ohio Revised Code 2305.321, Sections C(1) and C(2), for the benefit of the SHAW FARMS EQUINE & THERAPEUTIC CENTER Inc., according to the Ohio hose bill 564, Equine activity, sponsor, equine and/or property owner is not liable for any damages suffered during an equine activity on the SFETC premises. A horse is a large animal and may be unpredictable and dangerous at times and Extreme caution should be taken in their presence. Participants, observers, volunteers, attendees assume the inherent risks of equine activities. SFETC and It’s Affiliates and its duly Authorized Agents. Pursuant to Ohio Revised Code 2305.321, section C(2)a, the undersigned acknowledge that there are inherent risks associated with Equine Activities including, but not limited to:

* The property of an Equine to behave in ways that may result in injury, death or loss to persons on or around the Equine;
* The unpredictability of an Equine’s reaction to sounds, sudden movement, unfamiliar objects, persons or other animals;
* Hazards including but not limited to, surface or subsurface conditions;
* A collision with another Equine, another animal, a person or an object;
* The potential of an Equine Activity Participant to act in a negligent manner that may contribute to injury, death or loss to the person of the participant or to other persons, including but not limited to, failing to maintain control over an Equine or failing to act within the ability of the Participant.
* I further voluntarily agree and warrant to release and hold harmless this Shaw Farms Equine & Therapeutic Center and **all** its affiliates from liability whatsoever, including but not limited to, any incident caused by or related to Shaw Farms Equine & Therapeutic centers negligence, relating to injuries known, unknown, or otherwise herein disclosed including but not limited to, injuries, death or property damage from; mounting, riding, dismounting, walking, grooming feeding, use of horse barn, paddock, trails or horse ring, in any capacity, falling off horse whether horse is bucking, flipping, spooked or my failure to understand any equine professionals directions relating to riding or otherwise use and control, or lack of thereof, of my horse or the horse I have been assigned to. I understand I am also holding harmless Shaw Farms Equine & Therapeutic Center and **ALL** of its affiliate for any minors or persons that I am a lawful guardian or attendee by my invitation to this event.

I have read and understand the above inherent risks, have had the opportunity to have my questions answered, and understand the potential benefits and alternatives to this activity.

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

Participant’s/ Guardian Signature Date

Participant’s Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete section below if Participant is under Guardianship.

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

Guardian Signature (If different from authorized signature) Date

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

Guardian Printed Name

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**SEIZURE EVALUATION FORM**

If participant has **experienced seizure activity within the past 12 months**, this

**SEIZURE EVALUATION FORM IS REQUIRED**.

Consultation with the participant’s physician is recommended when completing this form.

*To Participants/Parents/Guardians/Treating Physicians: Please complete this form including as much information as possible. Riding and working around horses is an at risk activity. Health conditions that increase that risk need to be carefully analyzed. The safety of all participants, volunteers and horses is our utmost priority and careful consideration of all involved is mandatory.*

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

Participant Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Treating Seizures Physician’s Phone

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

Date(s) of last seizure(s) Type(s) of last seizure – please list all

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

Frequency of seizure(s) Duration of each seizure

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

Typical cause(s) of seizure activity, if known

Seizure activity indicator(s) – aura, behaviors or manifestations of oncoming seizure activity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is the participant able to express when a seizure may occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

After effects of seizure

During a seizure, I/my child/patient may:

* Stare briefly
* Walk around
* Perform aimless activities
* Suddenly cry / fall / become rigid, followed

by muscle jerks / saliva on lips / bluish skin color

* Experience loss of bladder or bowel control
* Be confused, have a headache, be fatigued;

followed by full return to consciousness

* Other, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Participant’s/Parent’s/Guardian’s Signature** **Relationship to Participant** Date

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**MEDICAL HISTORY & PHYSICIAN STATEMENT**

**MUST BE COMPLETED AND SIGNED ANNUALLY BY A MEDICAL PHYSICIAN**

Participant’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tetanus Shot: Yes or No When? \_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis/Disability \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Onset \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seizures: Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_ If yes, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last seizure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency of seizures \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate if the patient has had a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please explain in comments section.

|  |  |  |  |
| --- | --- | --- | --- |
| AREAS | YES | NO | COMMENTS |
| Auditory |  |  |  |
| Visual |  |  |  |
| Speech |  |  |  |
| Cardiac |  |  |  |
| Circulatory |  |  |  |
| Pulmonary |  |  |  |
| Neurological |  |  |  |
| Muscular |  |  |  |
| Orthopedic |  |  |  |
| Allergies |  |  |  |
| Psychological Impairment |  |  |  |
| Learning Disability |  |  |  |
| Mental Impairment |  |  |  |
| Other |  |  |  |

Please list all medical devices (feeding tubes, shunts, etc.):

Does Participant have *(please circle one for each)*:

Asthma Inhaler Yes or No Crutches Yes or No

EpiPen Yes or No Braces Yes or No

Wheelchair Yes or No Walker Yes or No

In the past 12 months, has the participant *(please circle one for each)*:

Been hospitalized for any serious injury, condition or surgery? Yes or No

Experienced loss of consciousness, including seizures? Yes or No

Experienced a psychotic crisis? Yes or No

Had necessary restrictions to activities for medical reasons? Yes or No

6 of 10 If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SPECIAL PRECAUTIONS**

The following conditions, although do not necessarily restrict a student from therapeutic riding, can represent

*precautions or contraindications* to the benefits of therapeutic riding, driving or non-mounted equine activities.

Therefore, when completing this form please note whether these conditions are present and to what degree. It is the responsibility of the parent/guardian and medical doctor to discuss and approve participant for therapeutic riding at SFETC.

**ORTHOPEDIC MEDICAL/SURGICAL**

Spinal Fusion or Abnormalities Allergies

Atlantoaxial Instabilities (Down Syndrome) Cancer

Scoliosis, Kyphosis, Lordosis Poor Endurance

Hip Subluxation or Dislocation Recent Surgery

Osteoporosis Peripheral Vascular Disease

Pathologic Fractures Hemophilia

Cranial Deficits Serious Heart Condition

Spinal Orthoses

Internal Spinal Stabilization Devices **SECONDARY CONCERNS**

Under Age of Four Years

**NEUROLOGICAL** Acute Exacerbation of Chronic Disorder

Hydroencephalus/Shunt Indwelling Catheter

Spina Bifida

Tethered Cord

Hydromyelia

Paralysis or Spinal Cord Injury

Seizure Disorder

Please indicate any special precautions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that **SHAW FARMS EQUINE & THERAPEUTIC CENTER (SFETC)** weigh medical information above against the existing precautions and contraindications. I concur with a review of the person’s abilities/limitations by a licensed/credentialed health professional in the implementing of an effective therapeutic equestrian program.

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

**Physician’s SIGNATURE**  **Physician’s PHONE NUMBER**

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

**Physician’s PRINTED NAME** **DATE**

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

**ADDRESS/STAMP**

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

**CITY** **STATE** **ZIP**

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**CLIENT ASSESSMENT and GOAL CHECKLIST**

Client’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the following that apply:

Cognitive Disability \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hearing Loss (Mode of Communication) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Speech \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emotional/Behavioral Disability \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fears \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Aggression \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the client have a history of seizures \_\_\_\_\_\_\_\_\_\_ Date of last seizure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of seizure does student experience \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency of seizures \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please note****: if the client has not been seizure free for a period of 12 months you- MUST -fill out the Seizure Evaluation Form included in this packet.*

What are you hoping to learn from this experience?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does the student have any unique issues (behavioral, social, etc.), how do you prefer to handle typical situations? Please include methods of behavior modification, communication and anything else that may be pertinent to the instructor working with this student.

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

To assist our instructors in formulating their lesson plans, please mark 3 items in each category which you/your child would like to work toward developing. Please prioritize items with #1 being the most important goal.

**PHYSICAL GOALS SOCIAL/RECREATIONAL GOALS COGNITIVE/EDUCATIONAL GOALS**

\_\_\_ Improved Balance \_\_\_ Socialization \_\_\_ Color Recognition

\_\_\_ Improved Posture \_\_\_ Cooperation \_\_\_ Shape Recognition

\_\_\_ General Coordination \_\_\_ Sportsmanship \_\_\_ Verbalization

\_\_\_ Eye/Hand Coordination \_\_\_ Enjoyment \_\_\_ Vocabulary Expansion

\_\_\_ Head Control \_\_\_ Confidence/Self Esteem \_\_\_ Sequencing

\_\_\_ Trunk Control \_\_\_ Communication Skills \_\_\_ Spatial Awareness

\_\_\_ Strength \_\_\_ Attention \_\_\_ Reading Skills

\_\_\_ Gross Motor Skills \_\_\_ Responsibility a. Letter Recognition

\_\_\_ Fine Motor Skills \_\_\_ Self-Sufficiency b. Word Recognition

\_\_\_ Decrease Tactile Defensiveness \_\_\_ Social Skill Development c. Basic Sentences

\_\_\_ Muscle Tone \_\_\_ Teamwork \_\_\_ Number Recognition

\_\_\_ Increased Range of Motion \_\_\_ Respect

\_\_\_ Sensory Integration \_\_\_ Independence

\_\_\_ Endurance \_\_\_ Trust

\_\_\_ Visual/Spatial Orientation \_\_\_ Interpersonal Relationships

COMPLETED BY:

**Assessor’s Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Student** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State** \_\_\_\_\_\_\_\_\_\_\_\_ **Zip** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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SFETC’s Eligibility Criteria and House Rules

* Weigh less than 150 pounds
* Are able to be effectively supported by side walkers
* Do not exhibit conditions that are contraindicated (listed under special precautions)
* Have current 2023- signed/ dated/returned paperwork acknowledged by SFETC
* Does not threaten the health or well being of other participants, horses, volunteers or staff
* Completed intake assessment with head instructor where it is determined that eligibility requirements are met
* Closed toe shoes are required, no sandals/crocs permitted
* SFETC works to accommodate days and lesson times, please allow 24 hour cancellation notice so that wait list participants can be accepted
* All minors (including siblings) must be supervised at all times
* No smoking any where on premises
* All students are required to wear a ASTM/SEI approved riding helmet
* No pets of any sort
* In the past, we have allowed siblings, volunteers etc. to ride the horses if time allowed. Due to insurance and work load of our equine partners, we will **not** be able to allow anyone other than approved participant to participate
* It is the responsibility of the participants to turn in a signed waiver for each person that enters the SFETC premises
* Participants **must** be accompanied by the parent/ legal guardian/grandparents
* ALL observers must stay in “observer approved area”

It is the participant’s responsibility to adhere to these criteria’s; SFETC focuses highly on the safety of its participants, volunteers and observers of the utmost priority.

I understand that participation in this program is dependent upon compliance by the participant/observer/affiliate with all policies, procedures and safety requirements of the SFETC Equestrian Center. Failure to comply may result in dismissal from the Program.

My signature herein indicates my acceptance of the above-specified stipulations. I hereby acknowledge that the aforementioned Client is applying for acceptance into SFETC Equine-Assisted Activities at **SHAW FARMS EQUINE & THERAPEUTIC CENTER**

Participant/guardian signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please initial:

~EQUINE ACTIVITIES PARTICIPANT REGISTRATION \_\_\_\_\_\_\_

~PHOTE RELEASE \_\_\_\_\_\_

~SFETC LIABILITY WAIVER (please print one per attending person)\_\_\_\_\_\_\_\_

~ SEIZURE EVALUATION FORM \_\_\_\_\_\_\_\_

~MEDICAL HISTORY & PHYSICIAN STATEMENT\_\_\_\_\_\_\_\_

~PARTICIPANT ASSESSMENT & GOAL ASSESSMENT\_\_\_\_\_\_\_\_\_\_

~ELIGIBILTY CRITERIA AND SFETC HOUSE RULES\_\_\_\_\_\_\_\_\_\_\_

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