PEGASUS

Pegasus Therapeutic Riding
310 Peach Lake Road
Brewster, NY 10509-1715

P: (845) 669-8235
F: (845) 669-5249
pegasustr.org

Founded in 1975, Pegasus is a PATH International Premier Accredited Center

Participant's Application and Health History

GENERAL INFORMATION

Participant name: _____ Date of birth: _____ Age: _____

Height: _____ Weight: _____ Gender: M ☐ F ☐ Email: _____

Address: _____ City: _____ ST: _____ Zip: _____

Primary phone: _____ H / C / W Alternate phone: _____ H / C / W

Participant's employer/school: _____

Mother/Guardian: _____ Email: _____

Home address: _____ City _____ ST _____ Zip _____

Home phone: _____ Cell: _____ Work phone: _____

Employer: _____ Occupation: _____

Father/Guardian: _____ Email: _____

Home address: _____ City _____ ST _____ Zip _____

Home phone: _____ Cell: _____ Work phone: _____

Employer: _____ Occupation: _____

****

HEALTH HISTORY

Diagnosis: _____ Date of onset: _____

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

Area	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Asthma			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

List all of participant's current prescription and over-the counter medications, including dose and frequency:

_____

_____

_____

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Describe abilities/difficulties in these areas (include assistance required or equipment needed):

Physical Function (e.g. mobility skills such as transfers, walking, wheelchair use, stair climbing):

_____

_____

_____

_____

_____

_____

Cognitive Abilities/Social Function (e.g. leisure interests; relationships/family structure; support systems; companion animals; fears/concerns; behavior challenges/strategies; work/school; communication abilities; reading/writing abilities):

_____

_____

_____

_____

_____

_____

_____

Goals (e.g. reason you are applying for participation and what you would like to accomplish):

_____

_____

_____

_____

_____

_____

_____

How did you hear about the program? _____

In addition to riding, we offer unmounted programs to learn general horsemanship skills and experience bonding with therapeutic animals. Please check here if you are interested and would like more information about these programs: ☐

Would you be willing to take your child out of school early in order to participate in our programs? Yes ☐ No ☐

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EMERGENCY MEDICAL TREATMENT INFORMATION

Name: _____

Physician's name: _____ Phone : _____

Preferred medical facility: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:

Name: _____ Relationship: _____

Phone H / C / W: _____

Name: _____ Relationship: _____

Phone H / C / W: _____

Name: _____ Relationship: _____

Phone H / C / W: _____

If 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 Pegasus Therapeutic Riding, Inc. 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.

CONSENT PLAN

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person(s) listed is/are unable to be reached. ☐ **CONSENT** ☐ **DO NOT CONSENT**

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LIABILITY RELEASE

As a participant at PEGASUS THERAPEUTIC RIDING, INC. I acknowledge the risks and potential for risks of horseback riding and related equine activities, including grievous bodily harm. However, I feel that the possible benefits to myself/my child/my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors, and administrators, waive and release forever all claims for damages against PEGASUS THERAPEUTIC RIDING, INC., its Board of Directors, Instructors, Therapists, Aids, Volunteers, Employees and/or any farms, stables, clubs and its officers, directors, employees, agents, landowner and members for any and all injuries and/or losses I/my child/my ward may sustain while participating in the Program from whatever cause including but not limited to the negligence of these released parties. This hold harmless agreement shall extend to all activities engaged in including but not limited to equine-assisted therapeutic activities and horseback riding. ☐ **CONFIRM**

PHOTO RELEASE

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to PEGASUS THERAPEUTIC RIDING, INC. permission to take or have taken still and moving photographs and films, including television pictures of my child/self and consents and authorizes PEGASUS THERAPEUTIC RIDING, INC., its advertising agencies, news media, and any others persons interested in Pegasus Therapeutic Riding, Inc., and its work, to use and reproduce the photographs, films and pictures and to circulate and publicize the same by all means including but not limited to newspapers, television media, email, website, social media, brochures, pamphlets, instructional material, books, clinical material, and any other form of media. With respect to the foregoing matters, no inducements or promises have been made to me/us to secure my/our signature(s) to this release other than the intention of Pegasus Therapeutic Riding, Inc. to use or cause to be used such photographs, films and pictures for the primary purpose of promoting and aiding PEGASUS THERAPEUTIC RIDING, INC. and its work. ☐ **CONSENT** ☐ **DO NOT CONSENT**

ACKNOWLEDGEMENT STATEMENT

"I certify that all the information provided on this form is true, accurate, and up to date, and guarantee to alert Pegasus staff to any changes or updates."

Signature: _____ **Date:** _____

Signature of parent/legal guardian/conservator of Participant in his/her name.
REQUIRED if Participant is under 18.

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BASIC RULES FOR PARTICIPANTS

ALL PARTICIPANTS WILL:

- Call the HOTLINE (845-669-8102) when unable to attend at regularly scheduled day and time – especially if your situation changes at the last minute.
- Will not bring dogs or pets on the property at any time. Exceptions will be made for service dogs.
- Walk when on the barn premises
- Use appropriate voices and avoid sudden movements, particularly near the horses
- Not chew gum or eat candy while riding or while in the riding arena
- Wear appropriate clothes and shoes for riding, avoiding loose or floppy items
- Wear a currently ASTM/SEI-approved helmet for all riding and stable activities
- Absolutely not smoke on the premises
- Not approach or feed any animals unless accompanied by Pegasus personnel who have been given explicit permission from the Pegasus instructor.
- Prior to the mounted and/or unmounted activities, inform the instructor of any changes in the participant's medical condition
- Prior to the mounted and/or unmounted activities, inform the instructor of any experiences which would affect the participant's behavior, safety or functions while at Pegasus
- Inform the instructor of any schedule changes or conflicts which would affect the participant's attendance

ALL OTHERS WAITING OR OBSERVING PROGRAM WILL:

- Closely supervise participants, siblings of participants or visitors while waiting in the designated waiting/observation areas.
- Remain outside the riding areas at all times
- Ask permission from the instructor to take photographs or video, especially with lights or a flash
- Wait for Pegasus personnel to mount or dismount the participants
- Not approach or feed any animals unless accompanied by a Pegasus personnel who has been given explicit permission by the Pegasus instructor
- Absolutely not smoke on the premises
- Use appropriate voices and avoid sudden movements particularly near the horses
- Remain at Pegasus location during participant activities, unless otherwise discussed with Pegasus personnel

Failure to follow the established safety procedures, demonstration of inappropriate and/or abusive behavior towards others, incidents due to the use of drugs or alcohol, and demonstration of mistreatment/abuse of equines and/or other animals on the site may result in immediate dismissal from Pegasus.

I have read and agree to adhere to the basic rules and procedures outlined above.

Signature **Date**

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Pegasus Therapeutic Riding, Inc.
COVID-19 Acknowledgement of Risk & Acceptance of Services

I, _____ (**Participant or Volunteer Name**), am aware of the risks of contracting COVID-19 while at Pegasus Therapeutic Riding, Inc. ("Pegasus"). I am aware that face to face services may increase my risk of contracting and passing on the COVID-19 Coronavirus and agree to hold harmless Pegasus, its staff, participants, volunteers and all others I may come in contact with during the time of services.

I agree to follow all guidelines and policies required by Pegasus including:

- Performing a self-health check prior to coming and cancelling services if I am exhibiting symptoms of COVID-19 or have been in contact with someone who has tested positive or presented symptoms of COVID-19 such as cough, congestion or runny nose, fever or chills, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea or vomiting or diarrhea.
- Following Pegasus's policies for personal protection, social distancing and disinfecting, including wearing face covering upon arrival and throughout activities.
- Understanding my family members or caregivers will be required to remain in their vehicle or wait for me in designated area only as indicated by staff.

Pegasus will engage in regular cleaning and sanitizing of riding equipment, grooming supplies, helmets and frequently touched areas in between lessons as recommended by the CDC.

I agree to follow these policies and hold harmless all individuals associated with my services at Pegasus Therapeutic Riding, Inc.

Signature **Date**

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Dear Health Care Provider:

In order to safely provide equine-assisted therapeutic services, our center requests that you complete/update the attached Medical History and Physician's Statement Form.

Please note the following conditions may suggest precautions and contraindications to horseback riding and other equine-assisted activities. Therefore, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability - include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Spina Bifida/Chiari II malformation/Tethered
Seizure

Other
Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Hemophilia

Medical Instability
Migraines
PVD
Cord/Hydromyelia Respiratory Compromise

Recent Surgeries
Substance Abuse
Thought Control Disorder
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/phone indicated above.

_____ _____

Physician's Signature **Date**

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Participant's Medical History and Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____ City: _____ ST: _____ Zip: _____

Diagnosis: _____ Date of onset: _____

Past/prospective surgeries: _____

Medications: _____

Special precautions/needs/diets/allergies: _____

Seizure type: _____ Controlled: Y N Date of last seizure: _____

Shunt present: Y N Date of last revision: _____

May participate in all activities ☐ May participate except for: _____

Mobility: Independent ambulation: Y N Assisted ambulation: Y N Wheelchair: Y N

Braces/assistive devices: _____

***FOR PERSONS WITH DOWN SYNDROME:** *Neurologic symptoms of Atlanto Axial Instability:* ☐ *Present* ☐ *Not Present*

Please indicate current or past special needs in the following systems/areas, including surgeries:

Area	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			

IMPORTANT NOTE TO DOCTOR/MEDICAL FACILITY:

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur this person's abilities/limitations may be reviewed by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name/Title: _____ MD DO NP PA Other _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone: _____ License/UPIN Number: _____

Signature: _____ Date: _____