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 Application and Health History **RENEWAL***

GENERAL INFORMATION

Participant name: _____

Height: _____ Weight: _____ Gender: M ☐ F ☐ Date of birth: _____ Age: _____

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

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

Primary email: _____

Participant's employer/school: _____

Mother/Guardian: _____ Email: _____

Home address: _____ City _____ ST _____ Zip _____

Home phone: _____ Cell phone: _____ Work phone: _____

Employer: _____ Occupation: _____

Father/Guardian: _____ Email: _____

Home address: _____ City _____ ST _____ Zip _____

Home phone: _____ Cell phone: _____ Work phone: _____

Employer: _____ Occupation: _____

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EMERGENCY MEDICAL TREATMENT INFORMATION

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____

Allergies: _____

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.

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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***

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. I have read and understood the foregoing and fully consent to the provisions contained herein. ☐ ***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***

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Describe abilities/difficulties in these areas (be specific and detailed as this will provide Pegasus staff with helpful information to develop session goals):

Physical Function (e.g. mobility skills such as assistance required, equipment needed, 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):

_____

_____

_____

_____

_____

_____

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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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 and be advised that there is an inherent risk of injury. 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/Low Bone Density
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Traumatic Brain Injury
Seizure Disorders
Hydrocephalus/Shunt
Spina Bifida/Tethered Cord/ Chiari Malformation

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

Medical
Allergies
Asthma
Cardiac Condition
Blood Pressure Control
Exacerbations of medical condition
Hemophilia
Peripheral Vascular Disease
Lack of Truncal Stability
Lack of Head/Neck Control
Recent Surgeries

Psychological
Animal Abuse
Physical/Sexual/Emotional Abuse
Fire Settings
Substance Abuse
Behaviors that can pose a safety risk

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.

_____ _____

Signature of Health Care Provider ***Date***

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Participant Medical History and Physician Statement

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

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

Diagnosis: _____ Date of onset: _____

Past/prospective surgeries: _____

Medications: _____

Allergies: _____

Special precautions/needs: _____Shunt present: Y N Date of last revision: _____

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

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 atlantoaxial 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 PA NP RN Other _____

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

Phone: _____ License/UPIN Number: _____

Signature: _____ Date: _____