Sarasota Manatee Association For Riding Therapy

4800 CR 675, Bradenton, FL 34211
941-746-1493
www.smartriders.org

Horses for Heroes Participant Application and Health History

Participant's Name: ____

DOB: ____ / ____ / _____ Age: ______ Height: ______ Weight: ______ Male / Female

Address: ____

Phone: __________ Alternate Number: ___________ E-Mail Address: ____________________

Care Giver: ____ Phone: ______________

Referral Source: ____

How did you hear about the program? ______________________________________

What medications are you currently taking, including over-the-counter medications? ______________

____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

Function: (i.e., mobility skills such as transfers, walking, wheelchair use)

____
____

Social: (i.e., work/school, leisure interests, relationships, family structure, support system, companion animals, fears/concerns, etc.)

____
____
____

Goals: (i.e. Why are you applying for participation? What would you like to accomplish?)

____
____
____

Photo Release

I ______ Do I ______ Do Not

Consent to and authorize the use and reproduction by SMART (Sarasota Manatee Association for Riding Therapy) of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: ____ Date: ____________________
Participant

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This form MUST be signed and dated by a MD, DO, NP, PA or other Medical Professional in the designated area at the bottom of this page!

Horses for Heroes Participant Medical History and Physician's Statement

Participant: ________________________________ DOB: ____ / ____ / ______ Height: ______ Weight: ______

Address: ____

Diagnosis: ____ Date of Onset: ____ / ____ / ______

Past/Prospective Surgeries: ____

Medications: ____

Seizure Type: ______________________________ Controlled: Y N Date of Last Seizure: ____ / ____ / ______

Shunt Present: Y N Date of last revision: ____ / ____ / ______

Special Precautions / Needs: ____

____

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

Braces / Assistive Devices: ____

Medical conditions:	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary / Skin			
Immunity			
Pulmonary			
Neurological			
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 equine assisted activities including therapeutic horseback riding and or carriage driving. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications.

PHYSICIAN'S SIGNATURE:____ **DATE: _____ / _____ / ______**

Clearly Print Name & Title: ______________________________________ License/UPIN Number _____________

Address: ____

Phone: (________) _________ - ______________ Please Indicate: MD DO NP PA Other______________________________

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RELEASE AND ASSUMPTION OF RISK AGREEMENT- Horses for Heroes Program

I, ______________________________________(print name clearly) agree to the following Release and Assumption of Risk Agreement with SARASOTA MANATEE ASSOCIATION FOR RIDING THERAPY, INC., a Florida nonprofit corporation (hereafter referred to as "SMART") as a condition for allowing me to enter SMART's premises, surrounding land, and other program locations, be near horses, participate in equine-assisted activities, work near horses, handle horses, use equipment, work with staff and volunteers, and/or receive instruction or guidance while riding, carriage driving, grooming, and handling horses. This is not meant to be a complete list of all activities and will be referred to in this document as "The Activities".

IT IS HEREBY AGREED AS FOLLOWS:
1. I have voluntarily requested to engage in any or all of The Activities, on this date and/or any future dates.
2. **Risks:** I understand that anyone engaging in The Activities can suffer bodily injuries, property damage and other injuries including death. Participation in The Activities involves certain inherent risks and, regardless of the care that is taken, it is impossible to ensure the safety of the participant. *I understand the risks and dangers inherent in The Activities, and I agree to assume them. I am not relying on SMART to list all possible risks for me.*
3. **Waiver and Liability Release**: As consideration for SMART allowing me to engage in The Activities at any time and at any location, I do hereby voluntarily assume all risks of loss, damage or personal bodily injury including death that may be sustained which may hereinafter occur on account of, or in any way arising from, entry upon the premises or participation in The Activities on or off the premises. I, for my heirs, administrators, personal representatives, or assigns, release and discharge SMART, Bridge Creek Inc., and all SMART employees, assistants, directors, instructors, volunteers, officers, land owners, and owners of horses from any and all claims, demands, damages, actions, omissions, suits, or causes of action (present or future).
3. **Indemnification:** I also understand and agree to indemnify and hold harmless SMART , Bridge Creek, Inc., and persons or entities working on behalf of or affiliated with SMART against any and all further claims or damages, cost or expenses incurred by SMART, Bridge Creek, Inc., and their employees as a result of an accident, injury or property loss which may occur while I am on or off the premises or engaged in The Activities connected with SMART which may result from negligence of the undersigned or the negligence of SMART, Bridge Creek Inc., employees, instructors, volunteers, agents, third parties or any combination thereof of SMART. The indemnification shall include reimbursement of SMART'S attorney fees.
4. **ASTM/SEI Headgear:** SMART will provide me with an equestrian safety helmet that is ASTM standard and SEI-certified for use if/when riding or driving horses. I understand that neither SMART or its assistants or agents can guarantee the suitability of any helmet provided.
5. **Health and Disabilities:** I understand that SMART requires a Medical History and Physician's Statement completed and signed by a medical professional before participation. SMART always recommends that I seek the advice of a physician if I am injured, and many of The Activities pose special physical risks to me as the participant.
6. Should I breach this Release (or any part of it) I agree to pay the attorney's fees and court costs related to such breach incurred by SMART and/or persons directly affiliated with SMART. It is also mutually agreed that any disputes arising under this Release, or any activities that are undertaken pursuant to this document, shall be litigated in a court of proper jurisdiction located in or nearest to Manatee County, Florida.

I expressly agree and understand that all parts of this Agreement shall apply to me and are intended to be as broad and inclusive as permitted by the Laws of the State of Florida.

I understand that when signed, this Agreement is intended to be legal, valid and binding at all times, now and in the future, when SMART permits me to engage in any or all of The Activities either on the SMART premises or other designated program locations.

WARNING: Under Florida Law, an equine activity sponsor or equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.

SIGNATURE OF PARTICIPANT ____DATE ________________

ADDRESS ____

CITY ____ STATE_________ZIP CODE____________________

PHONE (Home)________________________ (Cell / other)___________________Email:_____________________________

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Authorization for Emergency Medical Treatment

CONSENT PLAN:

In the event emergency medical aid/treatment is required due to illness or injury while participating in the Sarasota Manatee Association for Riding Therapy (SMART) program, I authorize SMART to secure and retain medical treatment and transportation if needed. This authorization includes but is not limited to x-ray, surgery, hospitalization, medication and any treatment deemed "life-saving" by the physician. In addition, I authorize SMART to release my records to any individual involved in medical treatment and/or transportation I might need. This provision will be invoked only if the emergency contact person(s) listed below is/are unable to be reached.

Date: _____ / _____ / _________ Participant's Name (print) ___________________________________ DOB: _____________

Home Phone Number: (____) _____________ Street Address: ____

City: ____ State: __________ Zip Code: _____________

In case of emergency, contact:

Name: ________________________________ Relationship: ________________ Phone Number(s): (____) _________________

Name: ________________________________ Relationship: _________________ Phone Number(s): (____) ________________

Physician's Name: ____ Phone Number: (____) __________________

Preferred Medical Facility: ____

Allergies to Medications: ____

Current Medications: ____

____

Health Insurance Company: ____ Policy Number: _________________________

Consent Authorized Signature ____ Date: _______________________
(Participant or Legal Guardian)

NON-CONSENT PLAN:

I do not give my consent for emergency medical treatment in the case of illness or injury while participating in the SMART program. In the event emergency treatment is required, I wish the following procedures to take place: (list procedures)

____

____

Date: ________________________ Participant's Name (print): ____

Non-Consent Authorized Signature: ____
(Participant or Legal Guardian)