HISTORY AND MISSION

Our mission: TO ASSIST CHILDREN WITH SPECIAL NEEDS THROUGH INTERACTION WITH HORSES. Our vision is to provide a high quality therapeutic horsemanship program that safely and effectively serves all persons with physical, mental, social, emotional, or behavioral disabilities through free, private riding, driving and interaction with the horses.

Horse therapy is not only recreational. It gives children and adults with disabilities, women and children who are victims of abuse, and at-risk youth the confidence they need to break down the barriers that have historically prevented them from entering the job market and mainstreaming as self sufficient and valuable members of society. The incentive to learn, to try, to achieve is magnified greatly when their goal is horse-oriented. If they can learn to ride or drive a horse, which many of their friends cannot do, they can do almost anything!

While legislation has removed many important roadblocks for people with disabilities, none is so overwhelming as a lack of self-confidence and underdeveloped learning and communication skills. These skills are vital if they are to become equal participants in a society designed for the able-bodied, forward, and self-confident. Horse therapy provides those with disabilities and youth at-risk these skills and the self-confidence to use them.

Heavenly Hooves is an affiliate center of SpiritHorse International, Corinth, Texas

HEAVENLY HOOVES THERAPEUTIC & RECREATIONAL RIDING CENTER

Participant's Application and Health History

GENERAL INFORMATION

Participant: ______________________________

DOB: __________ Age: ______ Height: ________ Weight: ________ M F

Address: ______________________________

Phone: ____________________ Alternative #: ____________________

Employer/School: ______________________________

Address: ______________________________

Phone: ______________________________

Parent/Legal Guardian: ______________________________

Address (if different from above): ______________________________

Phone: ______________________________

Referral Source: ______________________________

Contact Numbers: ______________________________

How did you hear about the program?: ______________________________

HEALTH HISTORY

Please indicate current or past problems in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognitive			
Allergies			

Parent/Guardian Employer ______________________________

(not required, but for our informational purposes only)

Email Address ______________________________

☐ **Yes, I give Heavenly Hooves permission to email me notices, updates, and any Information related to their programs.**

HEAVENLY HOOVES THERAPEUTIC & RECREATIONAL RIDING CENTER

Participant's Application and Health History

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, driving/bus riding)

____

____

____

SOCIAL (i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

____

____

____

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

____

____

____

____

PHOTO RELEASE

I DO/DO NOT consent to and authorize the use and reproduction by Heavenly Hooves Therapeutic & Recreational Riding Center 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: ___________

Client, Parent or Legal Guardian

HEAVENLY HOOVES THERAPEUTIC & RECREATIONAL RIDING CENTER

Authorization for Emergency Medical Treatment Form

[ ]Participant [ ]Staff [ ] Volunteer

Name: ____ DOB: ______________ Phone: ______________
Address: ____City/State/Zip:_______________________
E-mail address: ____
Physician's Name: ____
Medical Facility: ____
Health Insurance Company: _____________________________________Policy #: ___________________
Allergies to medications: ____
Current medications: ____

In the event of an emergency, contact:
Name: __________________________________Relation: __________________Phone: ______________
Name: __________________________________Relation: __________________ Phone:______________
Name: __________________________________ Relation: __________________ Phone: ______________

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 Heavenly Hooves Therapeutic & Recreational Riding Center 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 "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: ______________Consent Signature: ____
Client, Parent, or Legal Guardian

Non-Consent Plan

I do not give my consent for emergency medical treatment! aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment! aid is required, I wish the following procedures to take place:

____
____
____
____

Date: ______________Consent Signature: ____
Client, Parent or Legal Guardian

HEAVENLY HOOVES THERAPEUTIC & RECREATIONAL RIDING CENTER

Release of Liability

This Release of Liability is made and entered into on this date ______and for thereafter between
Patricia Lynn Turner (Executive Director) and Heavenly Hooves Therapeutic & Recreational Riding Center
and _________
(The Participant); and, if Participant is a minor, their Parent or Legal Guardian _________
In return for the use, today and on future dates, of the property, facility and services of the Executive Director, the Participant, his heirs, assigns and legal representatives, hereby expressly agree to the following:

1. It is the responsibility of the Participant to carry full and complete insurance coverage on his horse if he owns or leases one, personal property, and himself.

2. Participant agrees to assume Any And All Risks Involved In Or Arising From Participant's Use Of Or Presence Upon Executive Director's Property And Facility including without limitation the risk of death, bodily injury, property damage, all kicks, bites, collisions with vehicles, horses, or stationary objects, fire or explosion, the unavailability of emergency care, or the negligence or deliberate act of another person.

3. Participant agrees to hold Executive Director and all it's successors, assigns, subsidiaries, franchises, affiliates, officers, directors, employees and agents completely harmless and not liable, and releases them from all liability whatsoever, and Agrees Not To Sue them on account of, or in connection with any claims, causes of action, injuries, damages, costs or expenses arising out of the Participant's use of or presence upon Executive Director's property and facility, including without limitation, those based on death, bodily injury, property damage, including consequential damages, except if the damages are caused by the direct, willful and wanton negligence of the Executive Director.

4. Participant agrees to waive the protection afforded by any statute or law in any jurisdiction whose purpose, substance and! or effect is to provide that a general release shall not extend to claims, material or otherwise which the person giving the release does not know or suspect to exist at the time of executing this release.

5. Participant agrees to indemnify and defend Executive Director against, and hold it harmless from any and all claims, causes of action, damages judgments, costs or expenses, including attorney's fees, which in any way arise from the Participant's use of or presence upon the Executive Director's property or facility.

6. Participant agrees to abide by all of the Executive Director's safety rules and regulations.

7. If Participant is using his horse, the horse shall be free from infection, contagious or transmittable disease. Executive Director reserves the right to refuse horse if not in proper health, or is deemed dangerous or undesirable.

8. This contract is non-assignable and non-transferable, and is made and entered into in the State of Texas, and shall be enforced and interpreted under the laws of this State. Should any be in conflict with State law, then that clause is null and void. When the Executive Director and Participant, or Participant's Parent or Legal Guardian if Participant is a minor, sign this contract, it will then be binding on both parties, subject to the above terms and conditions.

9. Warning: Under Texas law (Chapter 87 Civil Practice and Remedies code) an Equine Professional is not liable for an injury to and/or the death of a participant in equine activities resulting from the inherent risks of equine activities.

Participant, Parent or Legal Guardian ____Date ________

HEAVENLY HOOVES THERAPEUTIC & RECREATIONAL RIDING CENTER

Participant's Medical History & 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: ______________________________________

For those with Down Syndrome: AtlantoDens Interval X-rays, date: Result: + —

Neurologic Symptoms of AtlantoAxial Instability:

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

	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			

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 with a review of this person's abilities/limitations by a licensed/credentialed health professional (eg PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name/Title: ______________________________ License/UPIN Number: __________

Signature: ______________________________________ Date: __________

Contraindications and Physician's Prescription

Date: _______________

Dear Physician:

Your patient,____,

is interested in participating in supervised equestrian activities.

In order to safely provide this service, our operating center requests that you complete/update the Medical History & Physician's Statement Form (see back). Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

ORTHOPEDIC

Atlantoaxial Instability - include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification / Myositis Ossifications
Joint Subluxation Dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion / Fixation
Spinal Instability / Abnormalities

NEUROLOGIC

Hydrocephalus/Shunt
Seizure
Spina Bifida / Chiari II malformation/Tethered Cord
Hydromyelia

OTHER

Indwelling Catheters
Medications - i.e. photosensitivity
Skin Breakdown

MEDICAL/PSHCHOLOGOCAL

Allergies
Animal Abuse
Physical/Sexual Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
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 therapeutic equine activities, please feel free to contact the operating center at the address/phone indicated below.

Sincerely, HEAVENLY HOOVES THERAPEUTIC & RECREATIONAL RIDING CENTER

Physician's Prescription

Client's Name: ____ **Phone:**_____________

Prescription for Therapeutic Horseback Riding

Prescription, where appropriate for evaluation and treatment by a Physical, Occupational and/or Speech Therapist in conjunction with the Therapeutic Horseback Riding Operating Center.

Recommended Frequency:

Precautions:

Physician's Signature: ______________________________________ **Date:** ______________

HEAVENLY HOOVES THERAPEUTIC & RECREATIONAL RIDING CENTER

Physical / Occupational Therapy Questionnaire

Client Name: ____________________________DOB: ___________ Age: ____________

Address: ____

Diagnosis: ______________________________Date of Request: ____________________

The above named client has applied for Therapeutic Horseback Riding Sessions at Heavenly Hooves. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input. It is our intent to use our program as an extension of the services you provide; therefore, the following information is very helpful to us. We want to assimilate your goals (both short term and long term) into ours for this person.

Specific Physical Therapy Needs to Address:

Current Treatment Goals: (we set 8-10 goals and evaluate progress every 12 weeks)

Recommended Gross Motor Activities:

Any Helpful Hints for Working with This Person:

____

Physical/Occupational Therapist (Please Sign) Date

Return To:

Heavenly Hooves Therapeutic & Recreational Riding Center
18897 Johnson Ln.
Farmersville, Texas 75442
(214) 995-0567 LynnTurner@HeavenlyHoovesRanch.com

Thank You for Your Participation!

HEAVENLY HOOVES THERAPEUTIC & RECREATIONAL RIDING CENTER

Special Education Teacher Questionnaire

Client Name: ______________________________ DOB: __________ Age: ______

Address: ____

Diagnosis: ______________________________ Date of Request: ____________

The above named client has applied for Therapeutic Horseback Riding Sessions at Heavenly Hooves. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input. It is our intent to use our program as an extension of the services you provide; therefore, the following information is very helpful to us. We want to assimilate your goals (both short term and long term) into ours for this person.

Specific Cognitive and/or Behavioral Needs to Address:

Current Treatment Goals: (we set 8-10 goals and evaluate progress every 12)

Recommended Activities:

Any Helpful Hints for Working with This Person:

____

Special Education Teacher (Please Sign) Date

Please return to:

Heavenly Hooves Therapeutic & Recreational Riding Center
18897 Johnson Ln.
Farmersville, Texas 75442
(214) 995-0567 LynnTurner@HeavenlyHoovesRanch.com

Thank You for Your Participation!

HEAVENLY HOOVES THERAPEUTIC & RECREATIONAL RIDING CENTER

Behavioral Therapy Questionnaire

Client Name: ____________________________DOB: ___________ Age: ____________

Address: ____

Diagnosis: ______________________________Date of Request: ____________________

The above named client has applied for Therapeutic Horseback Riding Sessions at Heavenly Hooves. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input. It is our intent to use our program as an extension of the services you provide; therefore, the following information is very helpful to us. We want to assimilate your goals (both short term and long term) into ours for this person.

Specific Behavioral Therapy Needs to Address:

Current Treatment Goals: (we set 8-10 goals and evaluate progress every 12 weeks)

Recommended Activities:

Any Helpful Hints for Working with This Person:

____

Therapist (Please Sign) Date

Return To:

Heavenly Hooves Therapeutic & Recreational Riding Center
18897 Johnson Ln.
Farmersville, Texas 75442
(214) 995-0567 LynnTurner@HeavenlyHoovesRanch.com

Thank You for Your Participation!

HEAVENLY HOOVES THERAPEUTIC & RECREATIONAL RIDING CENTER

Speech Therapy Questionnaire

Client Name: ______________________________________ DOB: ____________ Age: _______

Diagnosis: ____Date of Request: ________________

The above named client has applied for Therapeutic Horseback Riding Sessions at Heavenly Hooves. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input. It is our intent to use our program as an extension of the services you provide; therefore, the following information is very helpful to us. We want to assimilate your goals (both short term and long term) into ours for this person.

Specific Speech Therapy Needs to Address:

Current Treatment Goals: (we set 8-10 goals and evaluate progress every 12 weeks)

Recommended Oral Motor Activities:

Any Helpful Hints for Working with This Person:

____

Speech Therapist (Please Sign) Date

Return To:

Heavenly Hooves Therapeutic & Recreational Riding Center
18897 Johnson Ln.
Farmersville, Texas 75442
(214) 995-0567 LynnTurner@HeavenlyHoovesRanch.com

Thank You for Your Participation

HEAVENLY HOOVES THERAPEUTIC & RECREATIONAL RIDING CENTER

Dear Physician:
Your patient____
is interested in participating in supervised equestrian activities.
In order to safely provide this service, our operating center requests that you complete/update the Medical History & Physician's Statement (page 1). Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

ORTHOPEDIC

Atlantoaxial Instability include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossifications
Joint Subluxation Dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion / Fixation
Spinal Instability /Abnormalities

NEUROLOGIC

Hydrocephalus / Shunt
Seizure
Spina Bifida / Chiari II malformation/Tethered Cord
Hydromyelia

OTHER

Indwelling Catheters
Medications i.e. photosensitivity
Skin Breakdown

MEDICAL/PSYCHOLOGICAL

Allergies
Animal Abuse
Physical/Sexual Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
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 therapeutic equine activities, please feel free to contact the operating center at the address and phone indicated below.
Sincerely, Heavenly Hooves Therapeutic & Recreational Riding Center

Physician's Prescription

Client's Name: ____ Phone: _______

Prescription for Therapeutic Horseback Riding

Prescription, where appropriate for evaluation and treatment by a Physical, Occupational and/or Speech Therapist in conjunction with Heavenly Hooves Therapeutic & Recreational Riding Center.

Recommended Frequency:

Precautions:

Physician's Signature: _______________________________________ Date: _______________

Heavenly Hooves Therapeutic & Recreational Riding Center, 18897 Johnson Ln., Farmersville, Texas 75442
(214) 995-0567 LynnTurner@HeavenlyHoovesRanch.com