

PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Please print clearly and complete BOTH sides

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Physician Release for Equine Assisted Services at Greystone Manor Therapeutic Riding Center.

MEDICAL HISTORY

Date of Exam: _____

MUST BE SIGNED BY MD, DO, CRNP, FNP, or PA

Areas **MUST**
be filled in:

Name
DOB
Age
Height
Weight

Patient's Name: _____ DOB (MM/DD/YYYY): _____ Age: _____

Sex: M F Race (Optional): _____ Height: _____ Weight / lbs: _____

Diagnosis: _____ Date of Onset: _____

Tetanus Shot: (Circle one) No Yes (Date ___/___/___)

Allergies: _____

Medications (Type, Purpose, Dose): _____

Any new student entering the program as of 2021, must be under our 185 lb weight limit in order to ride at GMTRC. If the student is over this weight, they may be offered unmounted horsemanship lessons.

INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions or contraindications to equine assisted services. Therefore, please circle any conditions that are present and indicate to what degree.

ORTHOPEDIC

- Spinal Fusion
- Spinal Instabilities/Abnormalities
- Alanto-axial Instabilities
- Scoliosis
- Kyphosis
- Lordosis
- Hip Subluxation and Dislocation
- Osteoporosis
- Pathologic Fractures
- Coxas Arthrosis
- Heterotopic Ossification
- Osteogenesis Imperfecta
- Cranial Deficits
- Spinal Orthoses
- Internal Spinal Stabilization Disease

NEUROLOGIC

- Hydrocephalus/shunt
- Spina bifida
- Tethered Cord
- Chiari Malformation
- Hydromyelia
- Paralysis due to Spinal Cord Injury
- Seizure Disorders

SECONDARY CONCERNS

- Behavior Problems
- Age under 2 years
- Age 2 - 4 years
- Acute exacerbation of chronic disorder
- Indwelling catheter

MEDICAL/SURGICAL

- Allergies
- Cancer
- Poor Endurance
- Recent Surgery
- Diabetes
- Peripheral Vascular Disease
- Varicose Veins
- Hemophilia
- Hypertension
- Serious Heart Condition
- Stroke (Cerebrovascular Accident)

NOTE: Physician signature required on side 2 - please complete all areas applicable.

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Please indicate if patient has a history of the following secondary problems by checking YES or NO.
If YES, please include COMPLETE pertinent information.

AREA	YES	NO	COMMENTS	AREA	YES	NO	COMMENTS
Auditory				Muscular			
Visual Impairment			Glasses?	Independent Ambulation			
Speech Impairment				Crutches			
Allergies				Braces			
Cardiac				Wheelchair			
Circulatory				Neurological			
Learning Disability				Orthopedic			
Cognitive Impairment				Canine Assist			
Mental Impairment				Pulmonary			
Psychological Impairment				Other			
Seizures*			Type	Controlled			Date of last Seizure

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR PATIENTS WITH DOWN SYNDROME

If the patient has Down syndrome a full radiological examination establishing the absence of atlanto-axial instability is REQUIRED before they may participate in equestrian activities which, by their nature, may result in hyperextension, radical flexion or direct pressure on the neck or upper spine.

Yes No

- Has an x-ray evaluation for atlanto-axial instability been done? DATE of X-RAY _____
 If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

If this X-Ray is more than 1 year old please state the result of the most recent visual examination conducted within the past 6 months:

- The client has not had a timely physical examination and so cannot at this point be so certified.
 The client's annual physical examination reveals no symptoms of AAI
 The client's annual physical examination shows symptoms of AAI. Riding is CONTRAINDICATED.

CERTIFICATION: I have reviewed the above health information and examined the named participant. I certify that there is no medical evidence available to me that would preclude the participant's taking part in equestrian activities. This certification is valid for up to three years.

Physician's Signature: _____ **Print Physician's Name:** _____

PARTICIPANTS WITH SEIZURE DISORDER - Please Print clearly

The standards we have adopted have been developed by PATH (Professional Association of Therapeutic Horsemanship International) who recommends the following information for equine assisted service centers for riders with seizure disorders.

Would you consider participant's seizures to be?

- Completely controlled Very well controlled Fairly controlled by medication

Type of seizure:
Date of last seizure:
Typical motor activity during seizure:
Description of patient's behavior during seizure:

NOTE: PHYSICIAN'S SIGNATURE REQUIRED

I have reviewed the participant's health information and examined the named participant. I certify that there is no medical evidence available to me that would preclude the participant's taking part in **(please check) _____ mounted equestrian assisted services;** _____ **unmounted equestrian assisted services.**

Physician's Signature	Date:
Physician's Name (Please print):	Physician's Phone:
Address:	Physician's Fax:

**SIDE ONE: PARTICIPANT REGISTRATION
PRIMARY CONTACT INFORMATION**

**SIDE TWO: PHOTO / VIDEO RELEASE
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT
PROGRAM POLICIES ACKNOWLEDGEMENT**

**Please be sure to complete
all sections – incomplete
forms could delay
processing.**

REGISTRATION – PLEASE PRINT

(Remember to make a copy of this form for your records.)

DOB (MM/DD/YY)	Age:	Weight / lbs:	Height:	(Check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	Race (optional):
New Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No				How did you learn about GMTRC?	
Participant Employer or School:					
Diagnosis:					
PLEASE FILL IN <u>ALL</u> APPLICABLE INFORMATION BELOW:			Multiple sections may be filled in		
<input type="checkbox"/> SELF / PARTICIPANT:			<input type="checkbox"/> CHECK IF PRIMARY		
Participant Address:				City, State, Zip	
Email address(es):					
Phone – Home:	Cell:	Text? <input type="checkbox"/> Yes <input type="checkbox"/> No	Work:		
Alt Emergency Contact: (name)	Cell:	Text? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to Participant:		
<input type="checkbox"/> PARENT OR GUARDIAN:			<input type="checkbox"/> CHECK IF PRIMARY		
Parents' or Guardians' Full Names:					
Parents' or Guardians' Address (if different from participant):				City, State, Zip	
Email address(es):					
Phone – Home:	Cell:	Text? <input type="checkbox"/> Yes <input type="checkbox"/> No	Work:		
Alt Emergency Contact: (name)	Cell:	Text? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to Participant:		
Parent /Guardian place of employment: (Father)				(Mother)	
<input type="checkbox"/> CAREGIVER:			<input type="checkbox"/> CHECK IF PRIMARY		
Caregiver Name:			Group Home Name:		
Caregiver Phone:	(w)	(c)	Text? <input type="checkbox"/> Yes <input type="checkbox"/> No	(fax)	
In event parent/guardian or caregiver cannot be reached:	Contact:	Relationship:	Phone:		

Please complete side two

SIDE TWO: PHOTO / VIDEO RELEASE; AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT; YOUR AVAILABILITY FOR LESSONS

PHOTO / VIDEO RELEASE: (Check one) <input type="checkbox"/> I DO CONSENT <input type="checkbox"/> I DO NOT CONSENT	
I hereby (consent to or not consent to) the use and reproduction by Greystone Manor TRC of any and all photographs and any other audio-visual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, exhibitions, including website, Facebook or for any other use for the benefit of the program.	
Date:	Signature of Participant/Parent/Guardian:

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT – signature required on either Consent Plan or Non-Consent Plan	
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 Greystone Manor TRC to: 1) secure and retain medical treatment and transportation if needed; and 2) release participant records upon request to the authorized individual or agency involved in the medical emergency treatment.	
Print Physician's Name:	Phone:
Preferred Medical Facility:	Health Insurance Company:
	Policy No.:
Date:	Signature of Participant/Parent/Guardian:

CONSENT PLAN <input type="checkbox"/> I DO CONSENT	
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 listed below is unable to be reached.	
Date:	Signature of Participant/Parent/Guardian:
Printed Name:	Phone:
	Address:

NON-CONSENT PLAN <input type="checkbox"/> I DO NOT CONSENT	
I DO NOT give consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while on the property of the agency. If selected, an authorized adult (parent, guardian, caregiver) must be present on property at all times of service to act on behalf of the participant in case of emergency. In the event emergency treatment/aid is required, I WISH THE FOLLOWING PROCEDURES TO TAKE PLACE:	
Date:	Signature of Participant/Parent/Guardian:

PROGRAM POLICIES ACKNOWLEDGEMENT

BY SIGNING THIS FORM, YOU ACKNOWLEDGE THAT YOU HAVE RECEIVED, READ, AND UNDERSTAND THE PROGRAM PARTICIPANT POLICIES.

(Signature) PARTICIPANT _____	(Signature) LEGAL PARENT / GUARDIAN _____
(Print Name) PARTICIPANT _____	(Print Name) LEGAL PARENT / GUARDIAN _____
DATE: _____	DATE: _____



Therapeutic Riding Center
 PO Box 10724
 Lancaster, PA 17605-0724
 www.greystonemanortrc.org
 (717) 615-9222 main (717) 203-7388 volunteer coordinator

PLEASE CHECK ONE:

- Participant
- Volunteer
- Guest
- Other _____

PLEASE FILL OUT BOTH SIDES

**GENERAL ACTIVITY RELEASE, ASSUMPTION OF RISK and
 WAIVER OF LIABILITY AGREEMENT**

WARNING

You are advised that there are inherent risks in engaging in equine assisted services, including the risk of serious injury or death. By engaging in equine assisted services and in accordance with this agreement you hereby assume all risks of injury or death.

BY SIGNING THIS AGREEMENT, YOU ARE GIVING UP CERTAIN LEGAL RIGHTS, INCLUDING THE RIGHT TO RECOVER DAMAGES IN CASE OF INJURY, DEATH OR PROPERTY DAMAGE. READ IT CAREFULLY BEFORE SIGNING. YOUR SIGNATURE INDICATES YOUR UNDERSTANDING OF AND AGREEMENT TO ITS TERMS.

THIS AGREEMENT is made by and between LANCASTER COUNTY THERAPEUTIC RIDING, INC., a.k.a. GREYSTONE MANOR THERAPEUTIC RIDING CENTER, its administrators, directors, officers, volunteers, employees, sponsors, advertisers, and agents, hereinafter referred to as "Greystone Manor TRC" and _____, hereinafter referred to as "Participant."

Print Participant's Name

For consideration received, and in return for the use, today and on all future dates by me and/or my child of the facilities and property of Greystone Manor TRC, I AGREE for myself, and/or my child, my/our administrators and assigns, heirs, and representatives, as follows:

I ACKNOWLEDGE that there are inherent risks associated with equine assisted services such as described below, and I HEREBY EXPRESSLY ASSUME ALL RISKS associated with participating in such activities. Inherent risks are further described in the Pennsylvania Equine Activity Statute, 4 P.S. § 601 et seq., and include but are not limited to: the propensity of equines to behave in ways such as, running, bucking, biting, kicking, shying, stumbling, rearing, falling or stepping on, that may result in an injury, harm or death to persons on or around them; the unpredictability of equine's reaction to such things as sounds, sudden movement and unfamiliar objects, persons or other animals; certain hazards such as surface and subsurface conditions; collisions with other animals; the limited availability of emergency medical care; and the potential of others to act in a negligent manner that may contribute to injury, such as failing to maintain control over the animal or not acting within an individual's ability.

I AGREE to abide by and follow Greystone Manor TRC's rules and regulations, which shall be posted and/or available from time to time. I FURTHER ACKNOWLEDGE that the behavior of any animal is contingent to some extent upon my ability or that of my child. I assume all risks therefore.

I hereby, intending to be legally bound for myself, my heirs and assigns, executors or administrators expressly WAIVE AND RELEASE forever any and all claims for personal injury or property damage against Greystone Manor TRC for any and all injuries and/or losses I and/or my child may sustain.

I AGREE to hold harmless, indemnify and defend Greystone Manor TRC against, and hold harmless from, any and all claims, demands, causes of action, damages, judgments, orders, costs or expenses, including attorney's fees, whether actually incurred or not, which may in any way arise from or be in any way connected with Participant's use of or presence upon the property of Greystone Manor TRC and the facilities located thereon.

In the event that Participant is a minor, I, the parent or guardian shall FURTHER INDEMNIFY, DEFEND and HOLD Greystone Manor TRC HARMLESS from any such claims by said minor child, regardless of any statute of limitations or contractual limitation of actions.

In the event I am using my own horse, or a horse(s) not owned by Greystone Manor TRC, I WARRANT that said horse(s) shall be free from infection, contagious or transmittable diseases. Greystone Manor TRC reserves the right to refuse access or use of any horse upon the premises that does not appear to Greystone Manor TRC to be in good health, or is deemed dangerous or undesirable.

(Continued on Page 2)

GENERAL ACTIVITY RELEASE, ASSUMPTION OF RISK and WAIVER OF LIABILITY AGREEMENT Cont'd

If, during my participation in Greystone Manor TRC activities, I should need emergency medical treatment and I (and/or my minor child) am (are/is) not able to give my consent for or make arrangements for that treatment because of my injuries, I AUTHORIZE Greystone Manor TRC to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitalization.

I UNDERSTAND that I am expected and encouraged to obtain my own medical or health insurance coverage. I UNDERSTAND that Greystone Manor TRC assumes no responsibility for nor obligation to provide me with financial or other assistance, including but not limited to medical, health or disability benefits or insurance of any nature in the event of my injury, illness, death or damage to my property. I expressly waive any such claim for compensation or liability on the part of Greystone Manor TRC.

I agree to waive the protection of any applicable statutes in this 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 said release.

By signing below, I acknowledge that I enter into this release after having read it and that I place my signature on this release of my own free voluntary act and deed. By signing below, I represent to Greystone Manor TRC that I fully understand its contents, that I do not need any further explanation, and that I waive any further explanation.

ADULT Signature / Legal Guardian Signature(s):	Emergency Contact:
PRINT ADULT Name / Legal Guardian Name(s):	Relationship:
Date:	Phone:

PARENT / GUARDIAN WAIVER— FOR MINOR

If under eighteen (18) years of age, his or her parent or guardian must read and sign the following:

I, _____, acting as parent, natural guardian or legal guardian of _____ (hereinafter "the minor") hereby affirms that I have read the Agreement, understand that the Agreement is a release of all claims for injury, death and property damage. I consent to the terms on behalf of myself and on behalf of the minor, and agree to indemnify and save and hold harmless Greystone Manor TRC from any loss, liability, damage, or cost that it may incur because of any defect in or lack of capacity to act on behalf of minor in executing this Agreement.

MINOR Signature / Legal Guardian Signature(s):	Emergency Contact:
PRINT MINOR Name / Legal Guardian Name(s):	Relationship:
Date:	Phone:

PARTICIPANT POLICIES for AARON'S ACRES

Please review the following policies and sign the attached Acknowledgement form indicating that you have read and understand the policies. Keep this document for your reference.

Attire Policy

GMTRC strives to provide a safe environment for all our participants, volunteers, staff, and community members. As such, we encourage everyone to practice modesty and refrain from wearing attire that is ill-fitted or includes derogatory or offensive graphics. Jewelry (including necklaces, dangly earrings, and bracelets), scarves, or other items that may catch on the equipment or horse during activities will need to be removed prior to the start of service.

- Long pants are recommended for all mounted activities, regardless of temperature. Participants who arrive in shorts or short pants that do not adequately cover their legs may not be permitted to ride.
- Appropriate footwear is required for all services. This is defined as a hard soled shoe that encloses the entire foot. Shoes with some form of lace, zipper, or buckle are generally better than a slip-on shoe. Crocs, sandals, boat shoes, slippers, loafers, etc. are not adequate, and the student will not be permitted to participate in services. Please contact us if you have questions about whether or not a particular type of shoe will be acceptable.

In hot weather: Light weight, breathable fabrics are best. The ideal top should cover the participants shoulders; tank tops are discouraged for safety reasons. Participants are welcome to use our restroom facilities to change before and/or after their lesson.

Helmet Policy

GMTRC requires participants to wear an ASTM-SEI or international equivalent helmet for all equine-facilitated activities, mounted or unmounted. Instructors will check the fit of the helmet prior to the start of service and will make any adjustments necessary. GMTRC provides helmets for use by participants. Participants may use their own personal helmet if it meets the required safety and fit criteria.

Eligibility for Service

Below are criteria for participant eligibility:

- Participants must submit all required paperwork and documentation prior to the start of service.
- Participants must be at least four years of age.
- Participants must be able to sit up independently.
- Participants must be able to wear and sustain the weight of an approved helmet.
- Participants may not have any medical contraindications that prevent them from riding according to the contraindications set forth by PATH Intl.
- If participating in mounted activities, participants must not exceed the weight limit set for GMTRC horses (currently 185 lb maximum).



Program Phone: 717-615-9222
Finance Office: 717-844-1798
Fax: 717-553-0664

Insurance Policy: Due to liability and insurance requirements, all participants must have active health insurance coverage in order to participate in any programs or activities at Greystone Manor Therapeutic Riding Center. Participants must provide health insurance coverage information to GMTRC as requested on their registration form and must notify GMTRC of any changes, lapses, or discontinuation of coverage in an appropriate and timely manner.



Therapeutic Riding Center

PO Box 10724

Lancaster, PA 17605-0724

www.greystonemanortrc.org

(717) 615-9222 main

(717) 553-0664 fax

RELEASE TO BE COMPLETED BY PARENT OR GUARDIAN OF MINOR PARTICIPANT

I, _____, am the parent/guardian of _____, a minor on whose behalf I have submitted the attached application for participation in Greystone Manor Therapeutic Riding Center's (GMTRC) equine assisted services. I hereby represent that the above named minor has my consent to participate in GMTRC equine assisted services.

I further represent and warrant that, to the best of my knowledge and belief, the minor is physically and mentally able to participate in GMTRC equine assisted services. With my approval, a licensed physician has reviewed the health information contained in the minor's application and has certified, based on an independent medical examination, that there is no medical evidence, which would preclude the minor from participating in GMTRC equine assisted services.

I understand that if the minor has Down Syndrome and wishes to participate in GMTRC equestrian RIDING services, he/she cannot participate in sports or events, which, by their nature, result in hyper-extension, radical flexion, or direct pressure on his/her neck or upper spine unless he/she has had a full radiological examination, which establishes the absence of Atlanto-axial Instability. I am aware that the minor must have this radiological examination before he/she can participate in GMTRC equine RIDING services.

I have read this paper and fully understand the provisions of this release. I have explained these provisions to the minor. I understand that by signing this paper, I agree to the provisions of this release in my own behalf and on behalf of the minor named above.

Signature of Parent/Guardian _____

Print Name of Parent/Guardian _____

Date _____

Relationship to Participant _____



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RELEASE TO BE COMPLETED BY AN ADULT PARTICIPANT

I, _____, am at least 18 years old and have submitted the attached application for participation in Greystone Manor Therapeutic Riding Center's (GMTRC) equine assisted services.

I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in GMTRC equine assisted services. I also represent that a licensed physician has reviewed the health information contained in my application and has certified, based on an independent medical examination, that there is no medical evidence, which would preclude me from participating in GMTRC equine assisted services.

I understand that if I have Down Syndrome and wish to participate in GMTRC equestrian RIDING services, I cannot participate in sports or events, which, by their nature, result in hyper-extension, radical flexion, or direct pressure on my neck or upper spine unless I have had a full radiological examination, which establishes the absence of Atlanto-axial Instability. I am aware that I must have this radiological examination before I can participate in GMTRC equestrian RIDING services.

I have read this paper and fully understand the provisions of this release. I understand that by signing this paper, I agree to the provisions of this release.

Signature of Adult Participant _____

Date _____

I certify that I have reviewed this release with the participant whose signature appears above. Based on that review, I am satisfied that the participant understands this release and has agreed to its terms.

Name (print) _____

Signature _____

Relationship to Participant _____