



Unbridled Horse Therapy Client Application

Applicant Name: _____

Gender: _____

Height: _____ Weight: _____

Date of Birth: _____

Race/Ethnicity: _____

For grant purposes

Diagnosis: _____

Parent/Legal Guardian: _____ Relation: _____

Phone: (Home) _____ (Cell) _____ (Work) _____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ E-Mail: _____

Used for notification, newsletters, etc.

Name of Current School: _____

Referral Source: _____

Name of Your Employer: _____

Used for grant application purposes

****Every applicant must have page 1-7 completed along with a doctor signed diagnosis (page 8 & 9) to be put on our waiting list.**

If the applicant is a Victim of Abuse, Battered Women, or an At-Risk Youth, this does not apply.

Is the applicant a Victim of Abuse, Battered Women, or an At-Risk Youth? Yes No

SCHEDULING INFORMATION

Lesson times are Tuesday through Sunday from 9:15 AM - 6:00 PM. Each lesson is one hour including grooming, tacking up and untacking. For scheduling purposes, please check ALL times applicant is available.

| <u>Tuesday</u> | <u>Wednesday</u> | <u>Thursday</u> | <u>Friday</u> | <u>Saturday</u> | <u>Sunday</u> |
|----------------|------------------|-----------------|---------------|-----------------|---------------|
| 9:15 | 9:15 | 9:15 | 9:15 | 9:15 | 9:15 |
| 10:30 | 10:30 | 10:30 | 10:30 | 10:30 | 10:30 |
| 11:45 | 11:45 | 11:45 | 11:45 | 11:45 | 11:45 |
| 1:00 | 1:00 | 1:00 | 1:00 | 1:00 | 1:00 |
| 2:15 | 2:15 | 2:15 | 2:15 | 2:15 | 2:15 |
| 3:30 | 3:30 | 3:30 | 3:30 | 3:30 | 3:30 |
| 4:45 | 4:45 | 4:45 | 4:45 | 4:45 | 4:45 |
| 6:00 | 6:00 | 6:00 | 6:00 | 6:00 | 6:00 |

APPLICANT HEALTH HISTORY

Please indicate current/past problems in the following areas (Please include triggers, if any):

Vision: _____

Hearing: _____

Sensation: _____

Communication: _____

Heart: _____

Breathing: _____

Digestion: _____

Elimination: _____

Circulation: _____

Emotional: _____

Behavioral: _____

Pain: _____

Bone/Joint: _____

Muscular: _____

Thinking/Cognitive: _____

Allergies: _____

Any other information you feel we should know: _____

APPLICANT HEALTH HISTORY (continued)

Current Medications of Applicant (over-the counter included):

Please describe applicant's FUNCTIONAL abilities and difficulties, such as: mobility skills (transfers, walking, wheelchair use, driving/bus riding):

***Please describe assistance required or equipment needed:**

Please describe applicant's SOCIAL abilities and difficulties, such as: work/school (grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.):

***Please describe assistance required or equipment needed:**

APPLICANT INFORMATION

Goals (reason for applying; what would you like to see accomplished):

Please tell us about the applicant. (Likes: Favorite food, hobbies, pets, home life, siblings) (Dislikes: pets, sounds, etc.):

What types of things work best for the applicant in terms of rewards and motivation?

How does the applicant best communicate with others?

Spoken Language

Written Language

Sign Language ASL E/E

Communication device

Combination of the above (please describe)

Does the applicant use:

Echolalia (repeating words without regard for meaning)

Stemming (rocking, spinning, hand flapping)

Self-Regulatory Behavior (Please describe how the applicant uses this self-soothing behavior)

Do changes in the applicant's environment affect their behavior?

Never

Sometimes

Frequently

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Applicant Name: _____ Date of Birth: _____

Phone: (Home) _____ (Cell) _____ (Work) _____

Address: _____ City: _____ State: _____ Zip: _____

Medical Facility: _____ Phone: _____

Physician's Name: _____ Phone: _____

Health Insurance Company: _____ Policy #: _____

Allergies to Medications:

Current Medications:

Emergency Contacts:

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 Unbridled Horse Therapy to:

1. Secure and retain medical treatment and transportation if needed.
2. Release volunteer records upon request to the authorized individual or agency involved in the medical emergency treatment.

The CONSENT or NON-CONSENT Plan must be signed on the next page.

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Consent Plan

I **DO** give authorization that may include x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the emergency contact person(s) above is unable to be reached.

Signature: _____ Date: ____/____/____

If **under** 18 years of age, parent/guardian signature required below:

Signature: _____ Date: ____/____/____

OR

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:

Signature: _____ Date: ____/____/____

If **under** 18 years of age, parent/guardian signature required below:

Signature: _____ Date: ____/____/____

PHOTO AND VIDEO CONSENT

I, _____ **consent** OR **do not consent** to authorize the use and reproduction by Unbridled Horse Therapy of any and all photographs, video/audio materials taken of me for the purpose of on-going studies, educational activities, exhibitions, promotional materials or for any other use for the benefit of the program.

Signature: _____ Date: ____/____/____

If **under** 18 years of age, parent/guardian signature required below:

Signature: _____ Date: ____/____/____

CANCELATION POLICY

Unbridled Horse Therapy requires (a very liberal) notice of cancelation to be given a MINIMUM of 2 hours prior to clients scheduled therapy session.

If notice of cancelation occurs with less than 2 hours prior to that day's session then client will be charged \$30. If there is no notice of cancelation which results in a 'No Show', client will be charged full price of session.

Notice of cancellation can be given to instructor through phone call, text message, or email. Unbridled Instructor will respond to message confirming they received the cancelation. If you do not receive a message from instructor, please call Unbridled Horse Therapy or your personal instructor in order to refrain from being charged

Signature: _____ Date: ____/____/____

If under 18 years of age, parent/guardian signature required below:

Signature: _____ Date: ____/____/____

RELEASE OF LIABILITY

This Release of Liability is made and entered into on this date _____ and for thereafter
between Catherine Reams, Property Owner of Unbridled Horse Therapy and _____
(The Participant); and, if Participant is a minor, their Parent or Legal Guardian _____.

In return for 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/her horse if he/she owns or leases one, personal property, and him/her self.
2. Participant agrees to assume Any And All Risks Involved In Or Arising From Participant's Use Of Or Presence Upon Unbridled Horse Therapy, and the Property Owners 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 Unbridled Horse Therapy, the Property Owner and all its 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 Unbridled Horse Therapy, and the Property Owner's property and facility, including without limitation, those based on death, bodily injury, or property damage, including consequential damages.
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 Unbridled Horse Therapy and the Property Owner 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 Unbridled Horse Therapy and the Property Owner's property or facility.
6. Participant agrees to abide by all of Unbridled Horse Therapy's and the Executive Director's safety rules and regulations.
7. If Participant is using his/her horse, the horse shall be free from infection, contagious or transmittable disease. Unbridled Horse Therapy and the Property Owner reserve 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 Unbridled Horse Therapy, the Property Owner 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.

Signature: _____ Date: ____/____/____

If under 18 years of age, parent/guardian signature required below:

Signature: _____ Date: ____/____/____