



16680 W James Anderson Hwy
Buckingham, VA 23921
(434) 983-8181
www.heartlandhorseheroes.com

PARTICIPANT CHECKLIST

****This form is to be signed and returned with all paperwork****

____ Participant's Application and Health History - To be completed and signed by Participant/Parent/Guardian.

____ Heartland Horse Heroes/ Sprouse's Corner Ranch Waiver and Notice – To be completed and signed by Participant/Parent/Guardian.

____ Photograph and Media Release Form: To be completed and signed by Participant/Parent/Guardian.

____ Authorization for Emergency Medical Treatment – To be completed and signed by Participant/Parent/Guardian.

____ Participant's Medical History and Physician's Statement: to be completed by the participant's **physician**.

____ I have read and understand the policies that are established for HEARTLAND HORSE HEROES. I am to keep the policies and refer to them as needed.
I will contact the Head Instructor or Volunteer Coordinator should I have any questions regarding the policies stated.

I understand that all of the above information must be completed in full and returned to HEARTLAND HORSE HEROES before I can participate.

Participant's Name: _____

Signature: _____
(Must be 18 or older or parent/guardian must sign) (Date)

Print Name as shown above: _____



Participant's Application & Health History

Today's Date _____ Participant's Name: _____

DOB: _____ Age: _____ Weight: _____ Gender: M F

Address: _____

Phone _____ Email _____

Employer/School: _____

Parent/Legal Guardian: _____

Caregivers: _____

Caregiver Phone: _____

Diagnosis: _____ Date of Onset: _____

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

Areas	Yes	No	Comments
Vision			
Hearing			
Sensation			
Speech/Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Balance/Coordination			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			
Other			



**EQUINE ACTIVITY LIABILITY RELEASE, WAIVER OF
RIGHT TO SUE AND ASSUMPTION OF ALL RISKS**

This Equine Activity Liability Release, Waiver of Right to Sue and Assumption of all Risks Agreement ("this Agreement") is hereby given by the undersigned to Sprouse's Corner Ranch, LLC, LaRue Sprouse Dowd, and Heartland Horse Heroes as an equine activity sponsor and/or an equine activity professional (the "sponsor/professional") and/or as an owner of land upon which an equine activity to which the Agreement relates is conducted and each partner, officer, agent, employee, director, shareholder, member heir, personal representative, successor and assign of the sponsor/professional and of each owner.

In consideration for the opportunities provided by the sponsor/professional and each owner to the undersigned "participant" (including any minor participants for whom he signs this Agreement) for the enjoyment of equine activities as a participant, the undersigned "participant" (including any minor participant for whom he/she signs this Agreement) hereby agrees as follows:

1. This Agreement is given under the Virginia Equine Activity Liability Act (Code of Virginia 3.1-796.130 et seq.) as it may now provide or be hereafter amended (the "Act"). All terms defined by the Act shall have the same meaning herein, and the Act is hereby incorporated in this Agreement by reference. This Agreement shall be so construed as to provide to the sponsor/professional and/or owner the fullest protection of a release, waiver of right to sue and assumption of all risks which is afforded to the sponsor/professional and owner by the Act.
2. All pronouns shall be construed to include the masculine, feminine or neuter as well as the plural or singular, as may be appropriate to facilitate the construction of this Agreement in the light of the facts presented.
3. The participant hereby acknowledges that he/she has full and complete notice and understanding of the Act and of all the risks inherent in equine activities which may cause, contribute to or result in the death or personal injury of the participant or damage to the participant's property (the "Risks"), including, but not limited to: (i) the propensity of an equine to behave in dangerous ways or to trip and/or fall; (ii) the ability of anyone whomsoever to predict or foresee an equine's reaction to excitement, weather conditions, sound, movements, objects, persons, animals, reptiles, birds or insects, and the effects of such reactions; (iii) the hazards of surface or subsurface conditions, including but not limited to objects or conditions on, under or protruding from the surface, both latent and patent; (iv) the hazards which rocks, cliffs, hills, fences, trees, stumps, logs, bridges, ditches and other debris and obstacles, and any equine activity in connection therewith, may foreseeably or unforeseeably present; (v) the dangers and risks of tack or harness slipping or breaking for whatever reason; (vi) the dangers and risks of becoming entangled in tack, harness, or vehicles used in an equine activity, (vii) the risks of falling from or otherwise becoming unstable on an equine or a vehicle used in an equine activity for any reason whatsoever or for no identifiable reason and (viii) any negligent act or omission by the sponsor/professional or any owner which causes or results in the death or personal injury of the participant or damage to the participant's property (ix) and any dangers involved in catching, leading, or taking care of the horse.
4. The participant hereby RELEASES and WAIVES all rights which he/she may have or hereafter have against the sponsor/professional and each owner for death, personal injury or property damage which is in any way associated with the Risks; he/she does hereby WAIVE his/her right

to sue or to bring any action against the sponsor/professional or any owner in connection therewith; he/she agrees to INDEMNIFY and DEFEND the sponsor/professional and each owner from and to HOLD the sponsor/professional and each owner HARMLESS against any such suit or action, and he/she hereby expressly ASSUMES ALL RISKS AND DANGERS of death, personal injury and property damage which are in any way associated with the Risks enumerated in paragraph 3, above.

5. The participant hereby authorizes and consents to any emergency medical care which may at the time appear reasonably appropriate under the circumstances as a result of injury or sickness caused by or incurred in the course of an equine activity.

6. The Agreement shall remain valid and in full force and effect from and after the date opposite the signature of the participant until expressly revoked by the participant in a written notice personally delivered to the sponsor/professional and/or owner.

7. To the extent possible, this Agreement shall be construed in such manner as will render it, and each provision of it, fully enforceable; but if any provision of this Agreement shall be unenforceable, such provision (or so much thereof as is unenforceable) shall be deleted and the remainder of this Agreement shall continue in full force and effect.

8. If this Agreement is executed by the undersigned participant for and on behalf of a minor participant named below, the undersigned participant hereby warrants and represents that he/she is in fact the legal parent or guardian of such minor, with full rights of custody and control; that this Agreement is given on behalf of and is intended to be binding upon said minor participant, his heirs, personal representatives, successors and assigns; and the undersigned participant further agrees that this Agreement shall also be as fully binding on the undersigned participant as if it were entered into solely on his own behalf.

9. This Agreement shall be binding upon the heirs, personal representatives, successors and assigns of the participants.

10. I HAVE FULLY READ AND FULLY UNDERSTAND THE FOREGOING EQUINE LIABILITY RELEASE WAIVER OF RIGHT TO SUE AND ASSUMPTION OF ALL RISKS. I HAVE CONSULTED AND RELIED UPON MY OWN ADVISORS ON ALL QUESTIONS IN CONNECTION THEREWITH, AND I HAVE NOT RELIED UPON THE SPONSOR/PROFESSIONAL OR ANY OWNER FOR ANY ADVICE OR EXPLANATION IN CONNECTION THEREWITH.

BY SIGNING THIS WAIVER AND RELEASE I UNDERSTAND THAT I AM GIVING UP, WAIVING AND RELEASING ANY RIGHT THAT I MAY HAVE TO SUE OR MAKE A CLAIM WHICH I MIGHT HAVE OR WHICH MIGHT SUBSEQUENTLY ARISE OR OCCUR AGAINST THE SPONSOR/PROFESSIONAL AND OWNER FOR ANY INJURIES I MIGHT SUSTAIN WHILE HORSEBACK RIDING OR PARTICIPATING IN AN EQUINE ACTIVITY, AND THAT I AM INDEMNIFYING AND HOLDING HARMLESS THE SPONSOR/PROFESSIONAL AND OWNER FOR INJURING ANYONE ELSE OR ANY HORSE RIDDEN BY ANOTHER WHILE SO ENGAGED, IT IS MY INTENT TO GIVE UP THOSE RIGHTS AND PROVIDE THE HOLD HARMLESS AGREEMENT, AND I DO SO KNOWINGLY AND VOLUNTARILY.

Date _____

Participant's Name(s)(print) _____

Address _____

Phone Number(s) _____

Participant Signature (if over 18) _____

Parent/Guardian Signature (under age 18) _____



CONFIDENTIALITY POLICY

Confidentiality is defined as “told in secret or private relations; trusted.” Any information in regards to the participants of **HEARTLAND HORSE HEROES**; riders, their families, and volunteers shall remain privileged and confidential. This information may include, but is not limited to, any medical, social, referral, personal and/or financial information. Volunteers will be given information concerning students on a “need to know” basis and in keeping with the confidential nature of our clients’ record. Disclosure of any confidential information shall not be released to anyone not associated with **HEARTLAND HORSE HEROES**.

Photograph and Media Release

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to the **HEARTLAND HORSE HEROES**, permission to take or have taken still and/or moving photographs and films, including, but not limited to, television pictures of myself or my (son/daughter/ward) _____, and consents and authorizes the **HEARTLAND HORSE HEROES**, and its advertising agencies, news media and any other persons interested in the **HEARTLAND HORSE HEROES**, and its work, to use and reproduce the photographs, films, and pictures and to circulate and publicize the same by all means including without limiting the generality of the foregoing, newspapers, television media, brochures, pamphlets, instructional, clinical and/or research materials and books.

With respect to the foregoing matters, no inducements or promises have been made to me/us to secure our/my signature(s) to this release other than the intention of the **HEARTLAND HORSE HEROES**, to use or cause to be used such photographs, films and pictures for the primary purpose of promoting and aiding the program and its mission.

Dated: _____

Individual/Parent/Guardian/Caretaker

****NON-CONSENT FOR PHOTOGRAPH****

For reasons that I am not obligated to disclose, **IDO NOT GIVE CONSENT** for photographs, either still or moving, or any television or news media, to be taken of myself, or my son/daughter/ward, by the **HEARTLAND HORSE HEROES** or any persons working on behalf of said program. I understand that a **RED MARK** will be placed on the record kept in the administrative offices of the program, which will designate that photographs are not allowed of myself or said person.

Dated: _____

Individual/Parent/Guardian/Caretaker



AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

(Circle) Student Volunteer Instructor

Name: _____ DOB: _____ Age: _____
Address: _____
Telephone (w) _____ Telephone(other): _____ Email: _____
Physician's Name: _____ Telephone: _____
Medical Facility: _____
Health Insurance Company: _____ Policy #: _____
Allergies: _____
Current Medications: _____

In the event of 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 course of riding with the Heartland Horse Heroes Therapeutic Riding Program, or while being on said premises of the agency, I hereby authorize Heartland Horse Heroes Therapeutic Riding Program and/or its representatives to:

1. Obtain medical treatment and/or transportation if needed,
2. Release client records upon request to the authorized agency or its representative 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. The provision will only be invoked if the person below is unable to be reached.

Date: _____ Consent Signature: _____
Client (over age 18), Parent or Guardian

****NON-CONSENT FOR MEDICAL TREATMENT****

I/We **DO NOT** give my consent for emergency medical treatment in the case of illness or injury during the process of receiving services or while on the premises of the **Heartland Horse Heroes Therapeutic Riding Program**. In the event emergency treatment/aid is required, I wish the following procedure to take place: _____

Dated: _____ Signature: _____
Participant or Parent/Guardian/Caretaker



Participants Consent for Release of Information

I hereby authorize: _____ (person or facility)
to release information from the records of:

_____ (participant's name)

DOB: _____

This information is to be released to: _____
(center or therapist)

for the purpose of developing an equine activity program for the above-named participant.

The information to be released is indicated below:

- Medical history
- Physical therapy evaluation, assessment and program plan
- Speech therapy evaluation, assessment and program plan
- Mental health diagnosis and treatment plan
- Individual Habilitation Plan (IHP)
- Classroom Individual Educational Plan (IEP)
- Psychosocial evaluation, assessment and program plan
- Cognitive-behavioral management plan
- Other: _____

This release is valid for one year and can be revoked, in writing, at my request.

Parent/Guardian Signature: _____

Date: _____

Print Name: _____

Relationship to participant: _____

HHH Representative: _____

Please send materials to:

Heartland Horse Heroes
c/o Sprouse's Corner Ranch
16680 W James Anderson Hwy
Buckingham, VA 23921

****This is an initial letter to the participant's physician****

Date: _____

Dear Healthcare Provider:

Your patient: _____
(participant's name)

is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present and to what degree.

Orthopedic

Atlantoaxial Instability-include neurologic symptoms
Coxarthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (e.g. RA, MS)
Fire Setting
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Neurologic

Hydrocephalus/Shunt

Seizure

Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia

Other

Age-under 4 years

Indwelling Catheters/Medical Equipment

Medications- e.g., Photosensitivity

Poor Endurance

Skin Breakdown

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted services, please contact the center at the address/email/phone indicated below.

Sincerely,

LaRue Dowd

Executive Director

Heartland Horse Heroes

16680 W James Anderson Hwy

Buckingham, VA 23921

heartlandhorseheroes@ymail.com

(434) 983-8181

Participant's Medical History and Physician's Statement

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

Address: _____ Age: _____

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: _____

Tetanus Shot: Y N Date: _____

For those with Down syndrome: AtlantoDens Interval X-rays, Date: _____ Result: Pos. Neg.

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

Areas	Yes	No	Comments
Auditory			
Visual			
Tactile Sensations			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance/Coordination			
Orthopedic			
Allergies			
Learning Disabilities			
Cognitive			
Psychological/Emotional			
Pain			
Atlantoaxial Instability			
Other			

****The following is to be filled out by the Physician of record****

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 (e.g. PT, OT, speech, Psychologist, etc.) in the implementation of an effective equestrian program, if deemed necessary by the center.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ **Date:** _____

Address: _____

Phone: () _____ License/UPIN Number: _____

Medical History Continued

Medications (include prescription, over-the-counter; name, dose and frequency, side effects encountered)

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

Physical Function (mobility skills such as transfers, walking, wheelchair use, driving/bus riding):

Psycho/Social Function (work/school including grade completed, leisure interests, relationship-family structure, support system companion animals, fears/concerns, etc):

Goals (Why are you applying to participate? What would you like to accomplish?):

Dated: _____

Participant

Parent /Legal Guardian/Caretaker