Back In The Saddle Equine Therapy Center

334 College Hill Rd. / Hopkinton, NH 03229

(603) 746-5681 fax: (603) 746-3522

bitsetc2003@aol.com

www.bitsetc.org

CLIENT UPDATE PACKET

Hello to all BITS ETC Participants,

Thank you for your continued interest in our programs. We request that clients update their information annually so we may be aware of any pertinent changes.

Please send the attached medical forms to your primary care provider to update, and complete and return this abbreviated questionnaire.

As always, should you need to cancel your lesson we ask that you contact your instructor.

I look forward to seeing you all "back in the saddle!"

Best Regards,

Pauline Meridien

Director, BITS ETC

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REGISTRATION FORM

Participant Name_____

Primary Contact_____Phone_____

Address [street]_____ [city/zip] _____

E-Mail [please print clearly] _____

Age_____ Height_____ Weight_____

* * * * * * * * *

PHOTO RELEASE:

I ❑ DO ❑ **DO NOT** consent and authorize the taking and use / reproduction of any and all photographs, and or other audiovisual materials taken of me by BITS ETC for promotional, (printed, or web-based), exhibitions, educational activities, or for any other use for the benefit of BITS ETC.

_____ _____

Signature (Parent or Guardian if under 18) Date

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

❑ Participant ❑ Staff Member ❑ Volunteer

Name _____DOB_____

Address [street]_____[city/zip]_____

Phone [home]_____[cell]_____Email _____

Physician's Name_____Phone_____

Health Insurance Co ._____Policy #_____

Allergies to medications? _____

Current Medications_____

In the event of an emergency, contact:

Name_____Relation_____Phone_____

Name_____Relation_____Phone_____

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_____

(Parent or Legal Guardian if under 18)

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PARTICIPANT CONSENT FOR RELEASE OF INFORMATION

I hereby authorize _____ **Phone #**_____

(*Healthcare Provider, School, Other Party:* **PLEASE PRINT)**

To share protected personal information with Back In The Saddle Equine Therapy Center, 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
- Occupational Therapy evaluation, assessment and program plan
- Mental Health diagnosis and treatment plan
- Individual Habilitation Plan (IHP)
- Classroom Individual Education 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.

Name [please print] _____Phone _____

Relationship to Participant_____

Signature_____Date_____

(**Parent or Guardian if under 18**)

Please fax information to Back In The Saddle Equine Therapy Center at secure fax# (603) 746-3522, or mail to 334 College Hill Rd., Hopkinton, NH 03229

PARTICIPANT MEDICAL HISTORY AND PHYSICIAN 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: (circle one) Independent Ambulation Assisted Ambulation Wheelchair

Braces/Assistive Devices_____
For those with Down's syndrome: AtlantoDens Interval X-Rays done _____ Result: _____
Neurologic Symptoms of Atlanto-Axial Instability:_____

Please indicate current or past special needs in the following systems/areas, including surgeries. If "Yes," please explain.

	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			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the NARHA center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to BITS ETC for on-going evaluation to determine eligibility for participation.

Name _____MD DO NP PA Other_____

Signature_____ Date_____
Address_____
Phone ( )_____NPI #_____