EQUINE-ASSISTED SERVICES

PROGRAM APPLICATION

MADISON FIELDS

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21355 Big Woods Rd. Dickerson, MD 20842 | Office: 301.349.4007

10/2021

PARTICIPANT INFORMATION

Full Legal Name: _____

Date: _____ Age: _____ Date of Birth: _____

Gender: _____ Height: _____ Weight: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Mobile: _____ Text: Y / N

Email: _____

Primary Language: _____

PARENT/GUARDIAN/CAREGIVER

Name: _____

Relation: _____

Mobile: _____ Text: Y / N

Home Phone: _____

Work Phone: _____

Email: _____

MILITARY SERVICE

None _____ Current _____ Former _____

Branch: _____

Dates Served: _____

REFERRAL

How did you hear about the program? _____

_____

What activities are you interested in?

_____ Therapeutic Riding Lessons

☐ PRIVATE ☐ SEMI-PRIVATE (2 people)

_____ Equine-Assisted Learning (Unmounted)

OTHER CONTACTS

Physician: _____ Phone: _____

Employer/School: _____

Address: _____

Phone: _____

EMERGENCY CONTACTS

Name: _____

Relation: _____ Phone: _____

Name: _____

Relation: _____ Phone: _____

DIAGNOSIS

Primary: _____

_____

Secondary: _____

_____

Details: _____

_____

_____

Date of Onset: _____

THERAPIES

Please check all of the following therapies that the participant is currently utilizing.

_____ ABA (Applied Behavioral Analysis)

_____ Speech

_____ Occupation

_____ Physical

_____ Adaptive Art

_____ Adaptive Sports

_____ Other: _____

_____

HEALTH HISTORY

To be completed by Program Participant or by Parent/Legal Guardian.

Participant's Name: _____

Please indicate current or past difficulties in the following areas:

	Y	N	Comments		Y	N	Comments
Auditory				Muscular			
Visual				Balance			
Tactile Sensation				Orthopedic			
Speech				Allergies/ Reactions			
Cardiac				Learning Disability			
Circulatory				Cognitive			
Integumentary (Skin)				Emotional/ Psychological			
Immunity				Pain			
Pulmonary				Other			
Neurologic				Other			

MEDICATIONS

Please list any medications the Participant is currently taking..

_____

ABILITIES / CHALLENGES

Please describe your abitlity and the challenges you face in the following areas. Include any assistance/equipment required.

FUNCTIONAL (i.e. Mobility, Transfer Skills, Walking, Whellchair, etc.) _____

_____

SOCIAL (i.e. Workplace/School, Companion Animals, Comfort Objects, Fears/Concerns, etc.) _____

_____

GOALS

Please outline the things you would like to learn or accomplish in this program.

_____

AUTHORIZATION FOR MEDICAL TREATMENT

☐ PARTICIPANT ☐ STAFF ☐ VOLUNTEER

PERSONAL INFORMATION

Full Legal Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to Medicaions: _____

Current Medications: _____

EMERGENCY CONTACTS

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

AUTHORIZATION

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 Madison Fields to:

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

☐ CONSENT PLAN (Signed in the presence of Madison Fields Staff)

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 (Participant/Parent/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 (Participant/Parent/Legal Guardian)*

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM

PHYSICIAN STATEMENT

Date: _____

Dear Health Care Provider:

Your patient, _____ *Participant's Name* _____ , is interested in participating in supervised equine activities at Madison Fields. Madison Fields needs an update of his/her medical status. Please review the medical history form (see pages 1 and 2) and provide any updates to this information in the space provided below.

Please address occurrences over the past year including surgeries, illnesses, hospitalizations, medications, treatments, weight fluctionations or behaviors. Please reference the attached list of conditions that may suggest precautions and contraindications to equine activities and note whether these conditions are present, and to what degree. Please indicate current height/weight. If this person has Down Syndrome or any other condition that predisposes him/her to Atlantoaxial Instability, please include results of his/her neurologic exam.

Primary Diagnosis: _____ Height: _____

Secondary Diagnosis: _____ Weight: _____

Additional Information:

_____

_____

_____

_____

_____

_____

_____

Name/Title: _____ MD DO NP PA Other: _____

Signature: _____ Date: _____

Address: _____ Phone: _____

License/UPIN Number: _____

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PRECAUTIONS & CONTRAINDICATIONS FOR THERAPEUTIC RIDING

ORTHOPEDIC

Atlantoaxial Instability (include neurological symptoms)
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint Subluxation/Dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities
Scoliosis
Kyphosis
Lordosis

BEHAVIORAL
Including, but not limited to:

Biting
Hitting
Scratching
Spitting
Fire Setting
Other Combative Behavior

COMMUNICABLE DISEASES
Including, but not limited to:

Hepatitus A, B, or C
HIV/AIDS
MRSA
Tuberculosis

NEUROLOGIC

Hydrocephalus/Shunt
Seizure
Sina Bifida/Chiari II Malformation/Tethered Cord
Hydromyelia
Paralysis/Spinal Cord Injury

MEDICAL / PSYCHOLOGICAL

Allergies
Cancer
Poor Endurance
Diabetes
Varicose Veins
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (i.e., RA, MS)
Hemophilia
Medical Instability
Migranes
PBD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

OTHER

Age - under 2 years old
Age - 2 to 4 years old
Indwelling Catheters/Medical Equipment
Medications (i.e., Photosensitivity)
Skin Breakdown
Acute Exacerbation of a Chronic Disorder

SEIZURE STATEMENT

Required for Participants with History of Seizure Activity

Date Recieved: _____
office use only

A Seizure Statement is <u>required</u> for all participants with any seizure activity in the <u>last 10 years</u>.
Frequency of seizures varies widely and cannot always be predicted. Madison Fields wants to prepare horses, staff, and volunteers for correct and safe procedures to ensure client safety in case of a seizure.

Notify your instructor, therapist, or Madison Fields staff person as soon as possible if any changes occur! For clients with seizures – please provide the following information:

Client Name: _____ Type of seizure: _____

Typical aura/pre-seizure sensations or behaviors: _____

_____

_____

Typical motor activity during seizure: _____

_____

_____

Average duration of seizures: _____ Frequency: _____ Date of last seizure: _____

Description of behavior during the recovery state and its duration: _____

_____

_____

_____

What to do in the event of a seizure at Madison Fields: _____

_____

_____

_____

In my opinion, this individual can participate in equine-assisted services under appropriate supervision. However, I understand that Madison Fields will determine whether they can safely provide services.

Physician/Parent/Guardian Name (Print) _____ *Signature* _____ *Date* _____

Street Address _____ *City / State / Zip* _____ *Phone* _____

PARTICIPATION AGREEMENT

Assumption of Risk, Waiver of Liability, and Indemnification Agreement

This is an agreement between the student, client, health aide, volunteer, or spectator ("Participant") and Madison House Autism Foundation, Inc. d/b/a "Madison Fields". The purposes of this Participant Agreement ("Agreement") are (1) to affirm that the Participant has been fully informed of the risks and benefits of the particular activity or activities he/she wishes to partake, (2) to affirm that the Participant voluntarily consents to the risks involved in the selected activities, and (3) agrees to waive certain rights Participant legally may have under particular circumstances.

Check Applicable Activities:

- ☐ THERAPEUTIC RIDING PROGRAM
- ☐ AGRICULTURAL EDUCATION PROGRAM
- ☐ JOB READINESS PROGRAM
- ☐ FUNDRAISER EVENT
- ☐ VOLUNTEER TRAINING
- ☐ OTHER: _____

Assumption of Inherent Risks – Therapeutic Riding Program: The Therapeutic Riding Program may involve both mounted and ground activities with horses. I understand and assume the inherent risks involved in equine activities, which risks include, but are not limited to, bodily injury, physical harm, and even death to horses, participants, and spectators from handling or being in close proximity to horses which may occur in normal use. I acknowledge that the behavior of a horse is one based on a "flight-or-fight" instinct. Further, I understand that "inherent risks of equine activities" shall mean those dangers or conditions which are an integral part of equine activities, including, but not limited to:

- the propensity of any equine to behave in ways that may result in injury, harm, or death to persons on or around them and/or damage to property in their vicinity;
- the unpredictability of an equine's reaction to such things as sounds, sudden movements and unfamiliar objects, persons or other animals;
- certain hazards such as surface and subsurface objects;
- collisions with other equines, animals, people and objects (fixed or otherwise);
- limited availability of emergency medical care; and
- the potential of a participant or spectator to act in a negligent manner that may contribute to injury to the participant or others, such as failing to maintain control over the equine or to act within his/her ability.

Assumption of Inherent Risks – Agricultural Education and Vocational Programs: These activities may or may not involve the use of equines or other animals and may or may not require physical exertion on the part of the Participant. I understand and assume the inherent risks involved in participating in physical activities that may be involved in these programs. I also understand and assume the inherent risks involving living creatures, particularly horses as detailed above. I understand that participating in any type of fitness or physical activity will depend on my current state of physical and mental health and my own ability and willingness to participate. I realize

that participation in any type of physical activity or movement may place stress on the muscles, joints, and cardiovascular system of the body. Such activity could result in injuries ranging from common minor injuries (e.g., muscular soreness, strains, and sprains) to the infrequent more serious injury (e.g. torn ligaments, torn tendons, joint injuries, heat related injuries, stress fractures) to the rare catastrophic incident (e.g. heart attack, stroke, paralysis, death).

Waiver of Liability: For the privilege of participating, in those activities which I have selected above, today and on all future dates, I, on behalf of myself, my family members, my heirs, personal representatives, or assigns, do hereby agree to release, waive, and discharge Madison Fields and its directors, managers, employees, volunteers, and agents (hereinafter collectively referred to as "Madison Fields"), from any liability or responsibility for accident, damage, injury, or illness to myself while on the premises of and participating in Madison Fields activities resulting from the inherent risks of the selected activities I have chosen or from the ordinary negligence (active or passive) of Madison Fields. AND that except in the event of Madison Fields' wanton and willful and/or reckless conduct and/or gross negligence, I agree not to bring any claims, demands, actions and causes of action, and/or litigation, against Madison Fields for any economic and/or non-economic losses due to bodily injury, death, and/or property damage sustained by me in relation to the premises and operations of Madison Fields.

Indemnification: I also agree to hold harmless, defend, and indemnify Madison Fields (including, but not limited to, costs associated with defending a suit, judgment, courts costs, investigation costs, and reasonable attorney fees) from any and all claims of mine, my family members, or others arising from any injury or loss due to my participation in the activities I have voluntarily chosen to participate. I further agree to hold harmless, defend, and indemnify Madison Fields against any and all claims of co-participants, rescuers, and others arising from my conduct in the course of my participation.

Acknowledgements, Assertions, and Agreements: Participant affirms, acknowledges, and agrees to the following:

- ✓ I possess the physical condition and required mental competencies to participate safely or have the written permission from my personal physician or psychiatrist/therapist to participate in the activities I have selected.
- ✓ I have no physical condition which would preclude my participation. However, if I, in fact, do have a physical condition (e.g. heart problems, seizures, asthma, allergies) or a developmental or a psychological condition (e.g. autism, depression, anxiety, anger) that could preclude my participation I have fully disclosed this condition to Madison Fields and, if required, have presented a letter from my personal physician and/or psychiatrist or therapist stating I may safely participate.
- ✓ I agree to wear an ASTM/SEI approved riding helmet or similar protective head gear and other safety gear as may be required for my safe participation in any mounted program or activities.
- ✓ I may be asked to terminate an activity or program if Madison Fields deems my continued participation may be detrimental to me or others to safely participate.

Covenant not to Sue; Choice of Law; Statute of Limitations; Mediation; Venue; and Severability Clauses:
I promise not to sue Madison Fields for any present or future claim arising directly or indirectly from my participation in activities at Madison Fields. This includes claims resulting from the inherent risks of equine or physical activities and the active or passive negligence of Madison Fields.

This Agreement shall be construed and interpreted in accordance with the laws of the State of Maryland. The parties agree any action brought under this Agreement shall be brought within one (1) year of the incident or dispute giving rise to said claim. I further agree that prior to litigation, such incident or dispute shall first be mediated by a trained Mediator I shall select from a list acceptable to Madison Fields. Costs of mediation shall be shared equally by the parties. In the event of litigation, all claims shall be brought in Montgomery County, Maryland in a court of competent jurisdiction. I agree the prevailing party shall be entitled to costs and fees associated with the litigation, including reasonable attorney fees and reimbursement of mediation fees.

I also expressly agree that this Participant Agreement is intended to be as broad and inclusive as permitted by the laws of the State of Maryland and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full force and effect. This Agreement does not apply to acts of gross negligence.

Acknowledgement of Understanding: I understand this is a legal document and that I am signing this Agreement freely and voluntarily, without coercion or duress. I understand I have the choice *not to participate* as a client, student, volunteer, health aide, or spectator at Madison Fields, and, therefore, not sign this Agreement. I understand there is no public policy in Maryland prohibiting the use of this waiver.

I have read this 2-page Participation Agreement and fully understand its terms. I understand that I am giving up substantial rights, including my right to sue Madison Fields, its clinicians, directors, managers, employees, volunteers, and agents for injuries or death resulting from the inherent risks of those activities I have voluntarily selected to participate or from the ordinary negligence (active or passive) of Madison Fields. I further acknowledge that I intend my signature to be a complete and unconditional release of all liability, including that due to ordinary negligence by Madison Fields to the greatest extent allowed by the laws of Maryland.

_____ _____

Signature *(must be at least 18yrs of age or legally competent to sign)* Date

Signee's Name *(if not the Participant)*: _____

Signee must be legally competent. If Participant is a minor (less than 18 years of age) or an individual (minor or adult) under the care and guardianship of another, the parental or guardian signature indicates full understanding of the above terms and, as may be permitted by law, is waiving both the rights of the minor Participant and the rights of the parent/legal guardian pursuant to this Agreement.

Participant's Name *(print legibly)*: _____

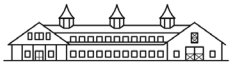
If Participant is a minor, what is relationship of Signee to Participant: ☐ Parent ☐ Legal Guardian ☐ Other: _____

_____

Signee's Address *(Street, City, State, Zip Code)*

_____

Participant's Address *(Street, City, State, Zip Code)*



MADISON FIELDS MEDIA RELEASE

In efforts to expand our programing and offerings, Madison Fields utilizes photography and video to educate the community about our mission, goals, and programs. Thank you for giving consideration to allow us to share the work we do here with our supporters.

_____ I hereby authorize and give my full consent to Madison Fields to utilize and publish any/all photographs, audio and or video in which I appear while participating in Madison Fields programs, activities and events. I understand I will not be compensated for media published and agree not to pursue any such compensation.

OR,

_____ I *do not* give my consent to Madison Fields to publish, transfer, or otherwise use any photographs, videotapes, or film in which I appear.

_____ _____

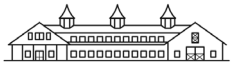
Participant's Name *(please print)* Date

_____

Signature *(must be at least 18yrs of age or legally competent to sign)*

Signee's Name *(if not the Participant)* _____

If Participant is a minor, what is relationship of Signee to Participant: ☐ Parent ☐ Legal Guardian ☐ Other:_____



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