Bit By Bit
Medical Therapeutic Riding Center
"Healing with the Help of a Horse"

Address: 3141 SW 118 Terrace, Davie, FL 33330
Office: (954)-246-9171 **Fax: (954)-414-8363** **Email: Info@bitbybittherapy.org**

"Horses For Heroes" Veteran's Program Registration

Directions from the West: From I-595 get off at Flamingo Rd. and head South. Turn Left on SW 26 St. Turn Right on SW 121 Ave/ Peaceful Ridge Rd. and Turn left onto SW 32nd Drive & then veer left onto cul-de-sac SW 118 th Terrace and we are at end of street. Directions from the East: If you are coming from the east, you may exit I-595 at Hiatus Rd and head south. Turn right at SW 26th St. Turn Left on SW 121 Ave/ Peaceful Ridge Rd. and turn left onto SW 32nd Drive & then veer left onto cul-de-sac SW 118 th Terrace and we are at end of street. Barn Address: 3141 SW 118 Terrace, Davie, FL 33330

Authorization for Emergency Medical Treatment

Name_____DOB: ____/____/_____Phone: (_____)-_____-_____
Address: _____City_____St _____ Zip _____
Email: _____
Physician: _____
Preferred Medical Facility: _____Health Insurance Company:_____
Allergies to any Medications: _____
Medications currently taking: _____

In Case of Emergency, contact:
Name: _____Relationship: _____ Phone: _____
Name: _____Relationship: _____ Phone: _____

In the event that 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 Bit-By-Bit to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency 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. This provision will only be invoked if the emergency contact person(s) above are unable to be reached.

Date: _____/_____/_____ Consent Signature: _____

OR *(Fill in below ONLY IF NOT CONSENTING to EMERGENCY TREATMENT)*

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 procedure(s) to take place:

_____

Date: _____/_____/_____ Non-Consent Plan Signature: _____

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Participant's Application and Health History

Name:				
DOB:	Age:	Height:	Weight:	Gender: M F
Address:			Phone:	
Email address:				
Referral Source:			Phone:	
How did you hear about the program?				

HEALTH HISTORY

Diagnosis: _____ **Date of Onset:**_____

Please indicate current or past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotion/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			Please list

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Participant Name:_____

Medications (*include prescription and over-the-counter)*

Name	Dose	Frequency

Please describe your abilities/difficulties in the following areas. (Include assistance required or equipment needed)

PHYSICAL FUNCTION (i.e. Mobility skills such as transfers, walking, wheelchair use, driving, bus riding)

_____

_____

_____

PSYCHO/SOCIAL FUNCTION (i.e. Work/ leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc)

_____

_____

_____

GOALS (i.e. Why are you applying for participation? What would you like to accomplish?)

_____

_____

_____

PHOTO RELEASE

X I DO (recommended) ☐ **I DO NOT**

consent to and authorize the use and reproduction by Bit-By-Bit of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Date:_____ Consent Signature: _____

Client

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Equine Professional Release

KNOW ALL MEN by these PRESENTS,

that _____(Write participant name) who resides at _____(write address) (hereinafter referred to as "participant), desires to engage in and hereby does engage in the services of Bit-By-Bit, Inc., and all of its, EMPLOYEES, Trainers, therapists, instructors, volunteers, board of directors, independent contractors, and others (hereinafter referred to as "EQUINE PROFESSIONAL"), LOCATED AT : 3141 SW 118th Terrace, Davie, Florida 33330 to instruct/provide services for the participant in recreational riding, riding lessons, therapeutic riding / adaptive riding lessons, camp, hippotherapy, physical, occupational, and/or speech therapy, medical therapy related services, equine care and management, equine assisted therapy or activities, horse shows, trail riding, Pony Scouts, horse training, parades, workshops, scouting programs, parties, fundraisers , public events, any and all independent contractor and/or volunteer activities, experiences, and duties, transportation and any other farm sponsored, charitable activity or equine activity.

FOR AND IN CONSIDERATION OF THE ABOVE SERVICES, Participant hereby does and forever and finally release, remise, acquit, satisfy and forever discharge Bit-By-Bit, Inc., and all of its, actions, cause and causes of actions, debts, dues, suit, sums of money, bonds, billings, contracts, controversies, agreement, promises, damages, variances, judgments, executions, claims, and demands whatsoever, including, but not limited to attorney's fees and disbursements, in law or in equity, which may arise or might in the future arise or hereinafter may arise for or against the Equine Professional for the services as stated above. This document is meant to be a full and complete release from all and any liability and release against any claims based on negligence, actions or inactions of the above named parties, and any claim that may arise from instructing the participant on how to properly ride, manage and care for horses and other animals, and all program activities, medical treatments, therapeutic activities, and/or animal related activities.

I hereby release the EQUINE PROFESSIONAL(S) from any and all liability from any injury or damage that may occur from participation in the inherently risky equine activities that may or may not be the result of either simple and gross negligence, and by signing this agreement acknowledge the possible risks and dangers that could result from participation in equine activities, whether caused by the equine sponsor's negligence or the inherent risks of equine activities. This release is given freely and voluntarily by the participant and is meant to remain in existence throughout the duration of any instruction, medical treatment, charitable, independent contractor, volunteer, or equine related activity. Photo release: I also consent to or (check only if applies- O do not consent to) and authorize the use and reproduction by Bit-By-Bit, Inc. of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

WARNING: Under Florida law, an equine activity sponsor or equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.

Dated this _____ day of _____, _____

Participant Name _____

Participant Signature _____

Phone _____

Complete Address _____

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FOR DOCTOR!! Attach with next page for physician signatures.

Date: _____

Dear Health Care Provider:

Your patient, _____
(Participant's name)
is interested in participating in supervised equine activities in our "Horses For Heroes" Therapeutic Riding Program. In our "Horses For Heroes" Program, we are offering **Hippotherapy** (Physical, Occupational, & Speech Therapy treatment on horseback) and **Recreational Therapeutic Riding Lessons** (Private and Group Lessons with a Certified Riding Instructor).

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement From. 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
Coxa Atthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord Hydromyelia

Other
Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions, (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the phone number(s) indicated below.

Sincerely,
Susan March, PT

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Participant's Medical History & Physician's Statement (for DOCTOR!)

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: Independent Ambulation ❍Y ❍ N Assisted Ambulation ❍Y ❍ N Wheelchair ❍Y ❍ N
Braces/Assistive Devices:_____

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

	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			

Doctor Prescription :

(Required ONLY for Medical Therapy)

Patient:_____
Date:_____
Rx (circle):

Physical therapy /
Occupational therapy/
Speech therapy
Evaluation and treatment

Signature:

_____
(Physician handwritten signature only)

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

*Name/Title:*_____ *MD DO NP Other* _____
*Signature:*_____ *Date:* _____ *Phone: ( )*_____
Address: _____ *License/UPIN Number* _____