LASATA

8 Abbott Lane Coatesville, PA 19320 Office: 610-886-4888

PARTICIPANT REGISTRATION INFORMATION

GENERAL INFORMATION

Participants Name:_____ Date of Birth:_____ Age:_____
Address:_____
City:_____ State:_____ Zip:_____ County:_____
Gender:_____ Height:_____ Weight:_____*
**195 lb weight limit variable dependent upon ambulatory status, ROM and discretion of instructor*

Primary Phone:_____ Alternate Phone:_____
Parent/Legal Guardian Name:_____
Address (if different from above):_____
Email Address:_____
EMERGENCY CONTACT NAME AND PHONE NUMBER:_____

HEALTH HISTORY

(attach additional sheet if necessary)

Diagnosis(es)/Disability(ies) (physical, emotional, mental) with date(s) of onset:

_____
_____
If physically disabled, which limb(s) are affected:_____
Physical aids (check if applicable): Wheelchair:____ Walker:____ Canes:____ Glasses:____ Braces:____
Crutches:____ Hearing Aid:____ Contact Lens:____ Other (please specify):_____
Other Therapies Currently Receiving:_____
Current Medications:_____
_____
Psycho-social function (interests, family structure, support system, etc:_____
_____
Allergies (medication, environmental, food) If yes, please list:_____

Any additional information:_____
_____

Please mark any of the following that have been a recent or past issue, and provide specific comments where applicable. These items will not be used to prevent anyone from participating; rather, they are to assist us in best meeting your needs:

[ ] Mental health therapy:_____
[ ] Legal problems:_____
[ ] Grief/Loss:_____
[ ] Trauma:_____
[ ] Special assistance at school:_____
[ ] Substance abuse:_____
[ ] Family problems:_____

Continued on Back

Does the student….	YES	NO	Comments
Have a history of seizures?			
Follow simple directions?			
Have speech or language difficulties?			
Have communication difficulties?			
Have a fear of animals/horses?			
Walk independently?			
Have limited range of motion?			
Have decreased strength/endurance?			
Have poor balance (sitting/standing)?			
Have problems with gross motor skills?			
Have problem with fine motor skills?			
Have altered sensation? (specify)			
Have heart/circulation problems?			
Have digestion/elimination problems?			
Have bone/joint problems?			
Have breathing problems?			
Have emotional/behavioral problems?			
Have bladder problems?			
Have visual problems?			
Have hearing problems?			
Have skin problems (current or past)?			
Have violent outburst?			
Have emotional withdrawal, fears?			
Have problems with exhaustion (heat, over-exertion)?			

Does the participant have prior experiences with therapeutic riding, hippotherapy or equine assisted therapy of any kind? _____ YES _____ NO

If so, when and where? _____

GOALS

What would you like to accomplish (or see the participant accomplish) in our program?_____

_____

_____

What are your life goals or aspirations for the participant?_____

_____

_____

ADDITIONAL COMMENTS

Please provide any additional information you feel would be helpful in class selection and lesson planning for yourself or this participant_____

_____

_____

Please call Lasata at 610-886-4888 with any questions.

_____ _____

Participants Signature If Legally Able or Parent/Guardian Signature Date

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EMERGENCY TREATMENT RELEASE

Participant:_____ Date of Birth:_____
Disability(ies) and Date of Onset:_____
Parent/Guardian:_____
Address:_____
City:_____ State:_____ Zip:_____
Primary Phone (please specify home, work, cell):_____
Secondary Phone (please specify home, work, cell):_____

In the event I cannot be reached, Contact:_____ Phone:_____
Contact:_____ Phone:_____

Physician's Name:_____ Phone:_____
Physician's Address:_____
Health Insurance Provider:_____ Policy Number:_____
Preferred Medical Facility:_____

Allergies:_____

Describe any medical condition(s) requiring precautions/treatment and any medications with dosage(s):_____
_____
_____

_____ I GIVE MY CONSENT: In case of a medical emergency, the undersigned authorizes Lasata to provide such medical assistance as they determine necessary. The undersigned authorizes any licensed physician and/or medical facility to provide medical surgical care and/or hospitalization for the participant, including anesthetic, which they determine to be necessary or advisable, pending receipt of a specific consent from the undersigned.
OR
_____ 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:_____
_____

No participant can be accepted for horse assisted learning or therapy until this form has been completed and signed. If the participant is of legal age (18), he/she may complete the form if he/she is legally competent to do so. Riding instruction and horse assisted therapies will be under strict supervision, and although every effort will be made to avoid any accident, **NO LIABILITY** can be accepted by any of the organizations, employees, owners, directors, board members or volunteers concerned.
In the event of an 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 Lasata 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.

SIGNATURE: _____ DATE:_____
(Participant if Legally Able or Parent/Guardian)

PRINT NAME:_____ RELATIONSHIP TO PARTICIPANT:_____

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LIABILITY RELEASE

I agree to the following agreement with Lasata, a Pennsylvania based non-profit organization (hereafter referred to as "Center") as a condition for allowing me, and the persons identified below, to enter the Center's premises and surrounding land, be near horses and other farm animals, participate in equine-assisted activities, work near horses and other farm animals, handle horses and other farm animals, use equipment, work with the owners, director, other staff and volunteers, and/or receive instruction or guidance in riding, grooming, or handling of horses and other farm animals (these activities will hereafter be referred to in this document as "The Activities").

Participants Name:_____ Date of Birth:_____

Relationship to Lasata Farm: ____ Participant/Student ____Volunteer____ Staff _____ Event Participant_____ Boarder/Lessee

Parent/Guardian Name(s) or Spouse's Name:_____

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

Primary Phone:_____ Secondary Phone:_____ Email:_____

IT IS HEREBY AGREED AS FOLLOWS:

1. I have requested to engage in any or all of The Activities, now and/or in the future.
2. ***Risks***. I understand that anyone engaging in The Activities can suffer bodily and other injuries. Participation in The Activities involved certain inherent risks and, regardless of the care that is taken, it is impossible to ensure the safety of the participant. **I understand the risks/dangers inherent in The Activities, and I agree to assume them. I am not relying on the Center to list all possible risks for me.** I have discussed the potential risks The Activities pose to family members including those who may visit the Center.
3. ***Waiver and Liability Release***. As consideration for Center allowing me to engage in The Activities at any time and at any location, I agree to assume full responsibility for any and all bodily injuries, losses, or damages that I, my family, assistants, aids, friends, therapists, or anyone that accompanies me may sustain. I, for my heirs, administrators, personal representatives, or assigns, release and discharge Lasata and Lasata Farm LLC, their employees, therapists, aids, assistants, directors, volunteers, board members, land owners, and owners of horses from any and all claims, demands, damages, actions, omissions, losses, suits, or causes of action (present or future).
4. ***Indemnification***. I also agree to indemnify and hold harmless Lasata and Lasata Farm LLC, and persons or entities working on behalf of or affiliated with the Center against all damages, which are sustained or suffered by any third persons. The indemnification shall include reimbursement of Center's attorney fees. Should I breach this Release (or any part of it) I agree to pay the attorney's fees and court costs related to such breach incurred by Center and/or persons directly affiliated with Center. It is also mutually agreed that any disputes arising under this Release, or any activities that are undertaken pursuant to this document, shall be litigated in a court of proper jurisdiction.
5. ***ASTM/SEI Headgear***. Lasata can provide me with an equestrian safety helmet that is ASTM-standard or SEI-certified for use when riding, handling, or near horses; mandatory to be worn while participant is mounted. I understand that neither Lasata or its assistants or agents can guarantee the suitability of any helmet provided. You are welcome to purchase your own ASTM/SEI Equestrian approved helmet.
6. ***Health and Disabilities***. I understand that Center always recommends that I seek the advice of a physician, and many of The Activities pose special physical risks to the participant and even to the volunteer. I want Center to be Aware of the following physical conditions I have that may affect my ability to handle, ride, and/or be near an equine or other farm animal:

_____

8. ***Photo Release***. The above named participant hereby _____Authorizes _____Does Not Authorize the use and reproduction by Lasata of any and all photographs, other audiovisual materials taken of myself/my family/my ward for promotional and or printed materials, educational activities, exhibitions, social media or for any other use for the benefit of the program.
9. ***Policy of Confidentiality.*** All information including but not limited to, personal, medical, and financial documents is confidential.

Signature of Contracting Party:_____ Date:_____
Printed Name of Contracting Party:_____
(Participant if Legally Able or Parent/Guardian)
Signature of Other Contracting Party:_____ Date:_____
Printed Name of Other Contracting Party:_____

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PHYSICIAN CONSENT FORM-TO BE COMPLETED BY A PHYSICIAN

Lasata is a equine assisted program which provides therapeutic riding designed to benefit the riders physically, socially, and emotionally. Safety equipment and specially trained horses, staff and volunteers are used. In order to assure the fullest possible protection and greater personal benefit from the program, each rider is required to furnish the following medical information before being accepted as a riding student.

Participant's Name:_____ Date of Birth:_____
Parent/Guardian Name(s):_____
Address:_____ City:_____ State:_____ Zip:_____
Primary Phone:_____ **CURRENT HEIGHT**:_____ **CURRENT WEIGHT**:_____
****195 pound weight limit dependent upon ambulatory status, ROM, and therapist discretion****

Diagnosis(es):_____
Cause:_____ Onset:_____
Limbs Affected:_____
If spinal cord involvement, what vertebral level:_____

If Downs Syndrome, Atlantoaxial subluxation: _____Yes _____No
Cervical x-ray for Atlantoaxial subluxation: _____Positive _____Negative
Estimate of mental ability:_____
NOTE*: BECAUSE OF THE NATURE OF THE ACTIVITY OF HORSEBACK RIDING, NO INDIVIDUAL DIAGNOSSED WITH DOWN SYNDROME CAN BE ACCEPTED FOR RIDING INSTRUCTION WITHOUT AN ANNUAL MEDICAL CLEARANCE FROM A LICENSED PHYSICIAN THAT INCLUDES A NEUROLOGICAL EXAM THAT SPECIFICALLY DENIES ANY SYMPTOMS CONSISTENT WITH ATLANTOAXIAL INSTABILITY (AAI). THIS FORM MUST BE ACCOMPANIED BY A SIGNEDAND DATED STATEMENT FROM THEIR FACIISION THAT DENIES ANY SYMPTOMS CONSISTENT WITH AAI.*

Does this person demonstrate explosive/violent behavior or the potential for explosive/violent behavior?_____
If yes, please explain:_____

Medical History:_____
_____

Surgical Procedures:_____
_____

Medications:_____
_____

Defects in: [ ]Sight [ ]Hearing [ ]Speech [ ]Balance
[ ]Neuro-sensation [ ]Muscle Tone [ ]Coordination [ ]Mobility

Braces or assisted devices used? _____No _____Yes (please describe):_____
Is the participant ambulatory? _____Yes _____No

Comment if applicable:
Seizures:_____Controlled?_____ Date of Last Seizure:_____
Incontinence:_____

General Comments:_____

IN MY OPINION THE PATIENT NAMED ABOVE CAN RECEIVE RIDING INSTRUCTION UNDER APPROPRIATE SUPERVISION
PHYSICIAN SIGNATURE:_____ DATE:_____
PHYSICIAN'S PRINTED NAME:_____PHONE:_____
ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

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DATE:_____

_____

(Print Participants Name if Legally Able or Parent/Guardians Name)

give permission to Lasata to discuss case or seek medical records from:

_____

_____

_____

in order to better understand how to best serve the participant.

_____

(Participant)

_____

(Parent/Guardian)

_____

(Witness)