EQUINE-ASSISTED ACTIVITIES AND THERAPIES

Dear Prospective Participant:

Welcome to Bridle Paths, a nonprofit equine-assisted activities and therapies (EAAT) program located in Leesburg, Virginia. The mission of Bridle Paths is to offer strength, support, and healing to our clients through safe, effective, and high-quality EAAT.

We offer therapeutic horseback riding instruction, equine-assisted learning, and equine-assisted psychotherapy services to individuals and families faced with physical, cognitive, psychological, and emotional needs. The program serves those with a wide variety of challenges, including attention deficit disorder, cognitive impairments, brain injuries, autism spectrum disorders, anxiety and depression, seizure disorders, post-traumatic stress, and experiences of trauma. The program operates at a private barn located at 43247 Spinks Ferry Road in Leesburg, Virginia 20176. Our facility includes a large barn, indoor and outdoor arenas, and a climate-controlled viewing area, and is accessible from Route 7 and the Dulles Toll Road.

The therapeutic riding program at Bridle Paths offers adapted riding instruction to children, adolescents, and adults. In addition to mounted instruction, sessions incorporate groundwork in horse care and horsemanship. The focus in these sessions is the provision of emotionally attuned instruction and the cultivation of relationship and connection between client and horse, and with staff and volunteers as well. Each of our lessons is staffed with an instructor certified by the Professional Association of Therapeutic Horsemanship (PATH) International, as well as by trained and committed volunteers to conduct lessons safely. Weekly therapeutic riding sessions are priced at $70 per lesson.

The following forms must be completed and returned to permit participation in our program:

Participant's Application and Health History
Therapist's Evaluation
Authorization for Emergency Medical Treatment
Eligibility Considerations
Participant's Medical History and Physician's Statement
Student Contract and Attachments

Occasionally, EAAT are not appropriate forms of activity and the participant's instructor has the right to discontinue the sessions. Each case will be discussed with the participant/participant's parents, physician and primary therapist to determine if EAAT are deemed acceptable. In that regard, please review the enclosed participant eligibility requirements.

Thank you for your interest in EAAT!

Regards,

Kathleen M. Fallon
PATH, Intl. Certified Advanced Therapeutic Riding Instructor
PATH, Intl. Certified Equine Specialist in Mental Health and Learning
EAGALA Certified Equine Specialist

EQUINE-ASSISTED ACTIVITIES AND THERAPIES

PARTICIPANT ELIGIBILITY REQUIREMENTS

1. This program recognizes the inherent risks involved in equine-related activities, and each participant will be assessed using a risk/benefit analysis. Prior to placement in the program, the instructor will review the client's medical forms and consult with parent/guardian/medical personnel regarding any precautions or contraindications.

2. Considerations that will determine an individual's eligibility to participate in equine-related activities provided by this program will be based on the following:

    - Age – No client under the age of two will be accepted. Children between the ages of 2 and 5 will be considered for the program after thorough examination of medical records and consultation with parents/guardians, and will depend upon the availability of suitable staff and equines.
    - Cognitive/Behavioral Characteristics – For safety reasons, individuals with extreme behavioral problems that result in danger to themselves, equines, volunteers, or staff will be unable to participate in the program.
    - Height and Weight – Larger participants present an increased safety risk during mounting and during riding activities. The program can only accept clients who can be safely and humanely carried by program equines, and safely supported by staff and volunteers. NARHA guidelines, which provide that a horse should not carry more than 20 percent of his weight, will be adhered to.
    - Mobility and Alignment – Sufficient mobility of the hips and spine is necessary to accommodate to the size and movement of the equine, and to allow the participant to be positioned appropriately on the horse. The program will assess each participant to ensure that her or she is able to receive the benefit of the equine's movement through proper positioning and adaptive equipment. However, if the horse's movement continues to cause poor alignment and increased stiffness within the participant, discharge should be considered.
    - Environmental Considerations – The program reserves the right to cancel or modify lessons if environmental considerations negatively impact the client's safety/welfare. These considerations include: temperature, wind, barometric pressure, and allergens.

EQUINE-ASSISTED ACTIVITIES AND THERAPIES

ELIGIBILITY CONSIDERATIONS

Date:_________________________________

Dear Health Care 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/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and/or contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and if so, to what degree.

ORTHOPEDIC
Atlantoaxial Instability – include neurological symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

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

OTHER
Age – under 4 years
Indwelling Catheters
Medications, *i.e.* photosensitivity
Poor Endurance
Skin Breakdown

MEDICAL/PSYCHOLOGICAL
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbation of Medical Conditions
Fire Setting
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorder
Weight Control Disorder

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

bridlepaths@gmail.com ◆ 571-216-9089 ◆ www.bridlepathsva.org

EQUINE-ASSISTED ACTIVITIES AND THERAPIES

PARTICIPANT'S APPLICATION AND HEALTH HISTORY

GENERAL INFORMATION:

Participant: ____ Email: ______________________________
Address: ____
Phones – Home: ________________________Work: ____________________ Cell: __________________________
DOB: ________________ Age: ___________ Height: ______________ Weight: ______________ Gender: M F
Employer/School: ____ Phone: _____________________
Address: ____
Parent/Legal Guardian: ____
Address (if different than above): ____
Phones (if different than above): Home: _________________ Work: _________________ Cell: _________________

Are you available to ride on weekday mornings? Yes_____ No_____ If yes, which mornings?____________________
Referral Source:____ Phone: ______________________________
How did you hear about our program?____

HEALTH HISTORY:

Diagnosis:____ Date of onset:___________________________
Tetanus Shot: Y[ ] N[ ]

	YES	*NO*	*COMMENTS*
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

(continued on following page)

EQUINE-ASSISTED ACTIVITIES AND THERAPIES

MEDICATIONS (include prescription, over-the-counter: name, dose & frequency):

____

____

____

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/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fear/concerns, *etc*.)

____

____

____

____

____

____

____

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

____

____

____

____

____

____

____

OTHER INFORMATION:

____

____

____

____

____

____

____

DATE: ___________________________ SIGNATURE: ____

EQUINE-ASSISTED ACTIVITIES AND THERAPIES

THERAPIST'S EVALUATION

Date: __________

1. Name: ____ Sex: ______________________
2. Diagnosis: ____
3. Past Medical History (seizures, medications, surgery): ____
____
____
4. Communication (aids, impairment): ____
5. Vision (aids, impairment):____
6. Cognitive/Emotional: ____
   - Follows Commands: I Step _____ II Step _____ III Step _____ Complex: _____
   - Attends to task: Poor (0-1 min.) ____ Fair (1-5 min.) _____ Avg. (5 min.) _____
   - Frustration Tolerance : Poor _____ Fair _____ Good _____
   - Problem Solving: Poor _____ Fair _____ Good _____
   - Cooperation: ____
   - Attitude: ____
7. Visual/Perceptual (Intact vs. Impaired):
   - Left/Right Discrimination: ____
   - Body Image: ____
   - Body Scheme: ____
   - Position in Space:____
   - Neglect of Space:____
   - Crossing Midline:____
8. Mobility:
   - Wheelchair: _________________ Amount of assist to transfer: _______________________________
   - Adaptive Device:_______________ Amount of assist to transfer: _______________________________
   - Independent Ambulator: ________
9. Social Skills (Group): Parallel _______________ Interactive _______________
10. Dominance: Right Hand ______________ Left Hand _______________
11. Gross Motor (Poor, Fair, Good):
    - Head Control: ____
    - Sitting Supported: ____
    - Sitting Unsupported: ____
    - Standing Balance: ____

EQUINE-ASSISTED ACTIVITIES AND THERAPIES

12. Gross Muscle Tone:

	LUE	LLE	RUE	RLE
• Increased Tone:	______	_____	_____	_____
• Decreased Tone:	______	_____	_____	_____
• Mixed:	______	_____	_____	_____
• Normal:	______	_____	_____	_____

- Comments: ____

13. Range of Motion (List any gross limitations that we should be aware of):
    - RUE: ____
    - RLE: ____
    - LUE: ____
    - LLE: ____

14. Sensibility (List any gross impairments that may interfere with safety of rider):
    - RUE: ____
    - RLE: ____
    - LUE: ____
    - LLE: ____

15. Abnormal Reflexes (List and describe successful inhibitory patterns. Also note if reflex is obligatory.):

    ____
    ____
    ____
    ____

16. Spinal Instability, Joint Subluxations, *etc*. (List any spinal instability, joint subluxations, or other conditions that might be medically contraindicated for riding.): ____

____
____
____
____

17. Goals:
- Frequency of treatment: ____
- Short-term goals:______ ____
  ____
  ____
- Long-term goals: ____
  ____
  ____

Person(s) completing evaluation:

EQUINE-ASSISTED ACTIVITIES AND THERAPIES

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

( ) Participant ( ) Staff/Volunteer

Name: ____ DOB:__________________
Address:____
Phone(s) Home:__________________ Work:_________________ Cell:__________________

Physician: ___________________________ Preferred Medical Facility:__________________
Health Insurance Co.: _______________________________ Policy #_____________________
Current Medications:____
Allergies to Medications:____

IN THE EVENT OF AN EMERGENCY, CONTACT:

Name: __________________________ Relation:_________________ Phone:______________
Name: __________________________ Relation:_________________ Phone:______________
Name: __________________________ Relation:_________________ Phone:______________

In case emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while on the property of the agency, I authorize the program 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 emergency treatment.

CONSENT PLAN:

This authorization includes x-ray(s), 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 (are) unable to be reached.

Signature: ____ Date: ________________
Participant (if over 18) or Parent or Legal Guardian

NON-CONSENT PLAN:

I *do not* give consent for emergency medical aid/treatment 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 aid/treatment is required, I wish the following procedures to take place:

____
____
____

Signature: ____ Date: ___________________
Participant (if over 18) or Parent or Legal Guardian

EQUINE-ASSISTED ACTIVITIES AND THERAPIES
PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S 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: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair: Y N
Braces/Assistive Devices: ____
For those with Down Syndrome: AtlantoDens Interval X-rays, Date: _____________ Result: + —
Neurologic Symptoms of AtlantoAxial Instability: _ ____
Please indicate current or past special needs in the following systems/areas, including surgeries:

	YES	*NO*	*COMMENTS*
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disabilities			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the NARHA 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, SLP, Psychologist, *etc.*) in the implementation of an effective equine activity program.

Name/Title: ______________________________________ MD DO NP PA Other: _______________
Signature: ______________________________________ Date: ______________________________
Address: ____
Phone: ____________________________________ License/UPIN Number: ______________________

EQUINE-ASSISTED ACTIVITIES AND THERAPIES