Hope on Horseback
Therapeutic Riding Center
10370 Barton Road
PO Box 483
Waterford, PA 16441-0483
(814) 474-5276
program@hopehorseback.org

Office use only
Date Received:
Contacted by:
Date:
Comments:
Physician Ref.
Payment:

2025
Enrollment Application and Health History
For Veteran's Program

Please print neatly, complete all forms and return to Program Director at above address.

GENERAL INFORMATION

Applicant: _____

DOB _____ Age _____ Gender: M F Height _____(inches) Weight _____(lbs.)

(Due to safety considerations, any applicant who weighs more than 180 pounds will need approval from the Program Director.)

Address _____ City/State _____ Zip _____

Phone _____ Alternative # _____

Email _____

Branch of Service _____ Date of Service _____

Applicant's School/Employer _____

How did you hear about HOHB? _____

Does the applicant have any previous riding experience? _____

If yes, please describe _____

Spouse (if applicable) _____

Address (if different from above) _____

Phone & Email (if different from above) _____

PSYCHO/SOCIAL FUNCTION (i.e. 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?)

_____

_____

You will be contacted to set up an appointment with our instructors for an evaluation interview.

HOHB CLIENT LIABILITY AND MEDICAL RELEASE

The undersigned, in consideration of the instruction given in the horseback riding program furnished by Hope on Horseback Therapeutic Riding Center, does hereby release, discharge, and indemnify HOHB from all claims which the undersigned may have now or in the future resulting from personal injury, death, or property damage to the person or property, caused or in any way growing out of acts of HOHB. It is the understanding that HOHB and its personnel shall take all reasonable precautions regarding the operation of the riding program. I intend to be legally bound by this agreement.

Further, the undersigned authorizes any licensed physician and/or emergency medical personnel to provide any medical/surgical care and/or hospitalization for the client, including anesthetic, which they determine necessary or advisable, pending receipt of specific consent from the undersigned.

_____ Date _____

Applicant's Signature

PHOTO/PUBLICITY RELEASE

I hereby _____ **Hope on Horseback Therapeutic Riding Center** permission to use my name or
Give/ do not give
photograph(s) in its public relations efforts for the primary purpose of promoting Hope on Horseback Therapeutic Riding Center and for soliciting financial support for HOHB.

_____ Date_____

Applicant's Signature

HEALTH HISTORY

Diagnosis or disability _____

Date of Onset _____

Submitting a Physician's Release Form is advised, but
If the answer to any of the following
HEALTH QUESTIONS is YES, it is required.

Does the participant have (please circle):

Crutches	Yes or No	Walker	Yes or No
Braces	Yes or No	Wheelchair	Yes or No

Has the participant ever been treated for any of the following?
IF YES, check the box, provide date of occurrence and details.

YES		Date	Details
	Spinal condition i.e. injury, scoliosis, fusion		
	Brain Condition i.e. Cerebral Palsy, stroke		
	Bleeding or Clotting Disorder		
	Diabetes		
	Joint Complications such as hip dysplasia		
	Epilepsy		
	Heart Condition		
	Neurological condition (including seizures)		
	Pulmonary condition		
	Skin break down or pressure sores		

In the past 12 months, has the participant: Circle One

Been hospitalized for any serious injury, condition, or surgery? Yes or No

Experienced loss of consciousness, including seizures? Yes or No

Experienced a psychotic crisis? Yes or No

Has it been necessary to restrict the participant's activities due to medical reasons? Yes or No

If yes, provide details: _____

Does the participant need assistance to maintain an upright position or head control? Yes or No

A Physician Release is required if the participant answered yes to any of the health questions above.
I hereby affirm, to the best of my knowledge, the health history information is complete and correct.

Name of person completing this form: _____ Date: _____

Signature: _____Relationship to Participant _____

If the participant has experienced seizure activity within the past 12 months, the following Seizure Evaluation Form is required. Participants may wish to consult with their physician when completing the following:

SEIZURE EVALUATION FORM

Instructions: Participants / treating physicians – please complete this form including as much information as possible. Since riding and working around horses is a risk activity, conditions that increase that risk are carefully analyzed. The safety of all participants, volunteers and horses is considered.

Participant Names _____

Physician Treating Seizures _____Physician's Phone _____

Type of Seizure (if more than one, please list all types) _____

Date of last seizure _____Frequency of seizures _____Duration of each seizure _____

Typical causes of seizure activity _____

Seizure activity indicators (aura, behaviors, or manifestations of oncoming seizure activity) _____

_____

After Affect _____

During a seizure, I / patient (check all that apply):

- ☐ May stare briefly (How long?) _____
- ☐ May walk around
- ☐ May perform aimless activities
- ☐ May suddenly cry/fall/ become rigid followed by muscle jerks / saliva on lips/ bluish skin color
- ☐ May experience loss of bladder or bowel control
- ☐ May be confused, have a headache, be fatigued; followed by full return of consciousness
- ☐ Other. Please explain _____

Are you / patient able to know and express when a seizure may occur? What are the signs?

_____

Should you / patient experience a seizure while at HOHB, beyond employing general first aid, what actions do you suggest we take?

- ☐ Do nothing
- ☐ Dismount from horse
- ☐ Allow _____ minutes to rest and reorient
- ☐ Report observations to parents/guardians immediately
- ☐ Send note home to parent/guardian
- ☐ Other. Please specify

_____ _____

Signature of Participant Date

PHYSICAL FUNCTION (i.e. Mobility skills such as transfers, walking, wheelchair use, sitting balance)

Describe your abilities/difficulties (include assistance required or equipment needed)

_____

_____

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

	Y	**N**	**Comments (Please be as specific as possible)**
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Fatigue			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			
Seizures			

MEDICATIONS (*include prescription, over-the-counter, name, dose and frequency*)

_____

_____

Medical devices: Feeding tubes, shunts etc.: _____

_____

Return completed form to:

HOHB Program Director
PO Box 483
Waterford, PA 16441-0483