MSU Extension Equine Assisted Therapy Programs
at
The Elizabeth A. Howard 4-H Therapeutic Riding and Activity Center

1769 Old White Rd S West Point, MS
Cassie Brunson
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To be in compliance with national standards, we have established the following criteria for participation in therapeutic riding classes.

Minimum Age: 4 years old for therapeutic riding classes
2 years old for hippotherapy

In keeping with PATH Int. recommendations, the following rider weight limits have been established:

Height	Maximum Weight
Under 5' tall	150 pounds
5'-5'6" tall	175 pounds
5'6"-6" tall	200 pounds
6'5"-6'5" tall	250 pounds

Classes will be filled on the basis of needs, riding ability, and volunteer ability. Please encourage individuals who are interested in volunteering to contact Cassie Brunson.**There is a great need for committed volunteers!!**

Admission and Discharge Policy

It is the decision of our staff to admit or discharge a rider. The age and weight charts are provided above. Riders can be discharged from the Program for other reasons, such as failure to appear for classes, inappropriate behavior, or implications that the continuation of therapeutic riding is a contraindication.

A rider possessing the ability and desire to advance to a higher level of instruction than the Program offers will be discharged and given assistance in locating a program and/or instructor that meets his or her needs.

It is **MANDATORY** that all riders, volunteers, and staff ride with (ASTM-SEI) helmets or PATH approved alternative guidelines.
Safety stirrups, hard sole shoes or boots with heels are **MANDATORY** for all riders, volunteers, and staff. Stirrups and footwear must be approved by the instructor before mounting.

We look forward to having you with us to ride!

Sincerely,

Cassie Brunson
Program Coordinator

Participant's Application, Medical History and Physician's Statement

General Information

Name:_____ Date of Birth:_____

Current Weight:_____ Current Height:_____Gender:_____

Race (for grant purposes only):_____

Address:_____

City:_____State:_____ Zip:_____

Parent/Guardian Name(s):_____

Best Contact Phone:(___)_____Alternate Phone:(___)_____

E-Mail:_____

Caregiver name (if applicable):_____ Phone:_____

Caregiver email:_____

School (if applicable):_____ Grade:_____

Is the participant currently receiving occupational, speech, or physical therapy services? Y◯ N◯

If so, where and how frequently?_____

Health History

Primary Diagnosis:_____ Date of onset:_____

SecondaryDiagnosis:_____Date of onset:_____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Medications:_____

Tetanus Shot: Yes: ___No: ___ Date of shot:_____

Have you or your child been diagnosed with a seizure disorder?
If so, type?_____

Controlled: Y☐ N☐ Date of Last Seizure:_____

Shunt Present: Y☐ N☐ Date of last revision:_____

In Case of Emergency Contact:_____

Special Precautions/Needs:_____

Current or past experience of skin breakdown or pressure sores? Y☐ N☐

If so, when and how was it controlled/treated?

MISSISSIPPI STATE UNIVERSITY

ACTIVITY PARTICIPATION AGREEMENT

In consideration for participating in the Mississippi State University Extension Equine Assisted Activities and Therapies 4-H Program (MSU EAAT) (hereinafter "Activity") and other valuable consideration, I hereby RELEASE, WAIVE, and DISCHARGE Mississippi State University, the Board of Trustees of State Institutions of Higher Learning for the State of Mississippi, the State of Mississippi, their officers, servants, agents, and employees (hereinafter "RELEASEES") from any and all liability, claims, demands, actions, and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by me/my child, or to any property belonging to me/my child. WHETHER CAUSED BY THE NEGLIGENCE OF, OR A BREACH OF ANY EXPRESS OR IMPLIED WARRANTY BY, --THE RELEASEES, OR OTHERWISE, WHILE PARTICIPATING IN SUCH ACTIVITY, or while in, on or upon the premises where the Activity is being conducted or while in transit during and to and from said Activity. I further acknowledge that the Releasees, as public entities, do not carry liability insurance for this Activity and that in order to provide this Activity, and others like it, as part of the Releasees' educational program, it is essential that the Releasees not be subject to liability or such Activities sponsored by the Releasees may not be feasible in future public educational programs offered by the Releasees.

To the best of my knowledge, I/my child can fully participate in this Activity, I am fully aware of the risks and hazards connected with the Activity, and I hereby elect on behalf of myself or my child to voluntarily participate in said Activity, and to engage in such Activity knowing that the Activity may be hazardous to me/my child and my/my child's property. I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISKS OF LOSS, PROPERTY DAMAGE, OR PERSONAL INJURY, INCLUDING DEATH, that may be sustained by me/my child, or any loss or damage to property owned by me/my child, as a result of being engaged in such Activity. I further hereby COVENANT NOT TO SUE the Releasees and AGREE TO INDEMNIFY AND HOLD HARMLESS the Releasees from any loss, liability, damages, or costs, including, but not limited to, court costs and attorney's fees, that may result from my participation in said Activity. It is my express intent that this Activity Participation Agreement shall bind the members of my family and spouse (if any), if I am alive, and my heirs, assigns, and personal representative if I am not alive, and this Agreement shall be deemed as a RELEASE, WAIVER, DISCHARGE, INDEMNIFICATION, AND COVENANT NOT TO SUE the above RELEASEES. I hereby further agree that this Agreement shall be construed in accordance with the laws of the State of Mississippi. I further understand that the Releasees are not responsible for any medical costs associated with any injury or illness I may sustain resulting from my participation in this Activity.

WARNING

Under Mississippi law, an equine activity or equine sponsor is not liable for an injury to or the death of a participant in equine activities resulting *from the inherent risks of equine activities*, pursuant to Mississippi Code SS 95-11-1 *et seq*. IN SIGNING THIS RELEASE, I ACKNOWLEDGE AND REPRESENT THAT I have read the foregoing Activity Participation Agreement, that I understand it, that I sign it voluntarily as my own free act and deed, and that no oral or written representation or statements of inducements, apart from the foregoing written agreement, have been made. If I am under twenty-one (21), or otherwise unable to consent on my own behalf, I understand that a parent or guardian must also sign this Agreement indicating their separate and complete obligation to adhere to the terms of this Agreement. I execute this Agreement for full, adequate, and complete consideration fully intending to be bound by same.

_____ _____

Participant's Signature Date Parent/Guardian Signature Date

Participant Profile

Mobility: Independent Ambulation: Y☐ N☐ Assisted Ambulation: Y☐ N☐ Wheelchair: Y☐ N☐

Does the participant have previous riding experience? Y☐ N☐

If yes, please explain._____

Is the participant able to sit independently? Y☐ N☐

What are some of the participant's interests? (i.e. leisure interests, relationships/family structure, support systems, fears/concerns)

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

IEP Goals:

Photo Release

I DO☐

DO NOT☐

Consent to and authorize the use and reproduction by the MSU Extension Equine Assisted Activities and Therapy 4-H Program of any and all photographs and any other audial/visual materials to be taken of me for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

Signature:_____ Date:_____

Participant

Signature:_____ Date:_____

Parent/Guardian

Consent for Emergency Medical Treatment

Name _____ Date of Birth _____

Parent/Guardian:_____

Address:_____

Phone:_____

Disability _____ Date of On-set _____

Physician:_____

Address:_____

Phone:_____

Preferred Medical
Facility:_____

Does the rider have any medical condition(s) requiring special precautions or treatments (e.g., medication or food allergies)? Y☐ N☐

If you answered yes, please explain: _____

_____

In case of medical emergency, the undersigned authorizes Mississippi State University, acting through the adult on its staff who has actual care, control, and possession of the child, to consent to medical, dental, and surgical treatment of the child when the undersigned cannot be contacted. The undersigned represents to Mississippi State University that he or she is the child's parent and either (a) is not divorced from the other parent, or (b) is divorced from the other parent, but has been authorized by a written court order to give consent to medical and dental care and surgical treatment of the child. The undersigned will indemnify and hold Mississippi State University, including the Board of Trustees of State Institutions of Higher Learning of Mississippi, its officers, members, employees, and agents harmless if he or she is not empowered by law to give this consent. The undersigned authorizes any licensed physician and/or medical facility to provide any medical/surgical care and/or hospitalization for the child, including anesthetic treatment, which they determine necessary or advisable, pending receipt of a special consent from the undersigned. I understand I am responsible for full payment of any medical care provided and that the Releasees' insurance does not cover medical expenses in the event of an accident. No person can be accepted for riding instruction until this form has been completed by the parent/parents or guardian. If the person is of legal age (21), he or she may complete the form, if he or she is legally competent to do so. Although every effort will be made to avoid any accident, NO LIABILITY is accepted by Mississippi State University. Yes, I would like _____to have riding instruction at the MSU EAAT 4-H Program. If my child is a rider, I have discussed this with their physician. I have read and signed the attached "Activity Participation Agreement" and understand that the Releasees defined therin will not be liable in the event of any reliance on this document to consent to medical care.

Signature of Parent/or Guardian:_____ Date:_____

Signature of Rider Over Age of 21:_____ Date:_____

Rider/Parent Insurance
Provider:_____

Policy Number: _____

Non-Consent for Emergency Medical Treatment

I do not give my consent for emergency medical treatment/aid in the event of illness or injury during the process of receiving services or any participation on my part in the MSU EAAT 4-H Program. In the event of an emergency, I authorize Mississippi State University or its representative to take only the following action on my behalf.

Please notify the following individual(s) in the event of an emergency:

Name:_____

Phone:_____

No person can be accepted for participation in the MSU EAAT 4-H Program until either this form or the Consent for Emergency Medical Treatment form has been completed. If the person is of legal age (21), he/she may complete the form. If the person is not of legal age, the form must be completed by the parent(s) or guardian.

Activities will be appropriately supervised, and although every reasonable effort will be made to avoid any accident, NO LIABILITY can be accepted by Mississippi State University or any of the Releasees defined in the Activity Participation Agreement. By signing this “Non-Consent for Emergency Medical Treatment”, I hereby accept all responsibility, on behalf of myself/my child. By not consenting to the MSU EAAT 4-H program procuring medical care in the event of an emergency, I take full responsibility for nay consequences that may result.

Signature of Parent/Guardian:_____Date:_____

Signature of Participant Over Age21:_____Date:_____

Participant's Consent for Release of Healthcare Information

I hereby authorize _____

(Person or Facility)

to release information from the records of _____

(Participant's Name)

The information is to be released to _____

MSU Extension EAAT 4-H Program at the Elizabeth A. Howard TRAC

For the purpose of developing a Therapeutic Riding Program for the above-named student. The information to be released is marked below:

- ☐ Medical history
- ☐ Physical therapy evaluation, assessment and program plan
- ☐ Speech therapy evaluation. Assessment and program plan
- ☐ Mental health diagnosis and treatment plan
- ☐ Individual Habilitation Plan (IHP) Psychosocial
- ☐ Individual Education Plan (IEP) Classroom
- ☐ Evaluation, assessment and program plan -Cognitive-
- ☐ Behavioral Management Plan
- ☐ Other:_____

This release can be revoked, in writing, at my request.

Signature:_____ Date:_____

Print Name:_____

Relationship to Participant:_____

Information for Physician

Dear Health Care Provider:

Your patient, _____ DOB:_____

is interested in participating in supervised equine activities with MSU's Extension Equine Assisted Activities and Therapy Program.

In order to safely provide EAAT services, we request that you complete/update the attached medical forms.

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathological Fractures
Coxas Arthrosis
Heterotopic Ossification
Spinal Orthoses
Internal Spinal Stabilization Devices

Medical/Surgical
Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition.
Stroke (Cerebrovascular Accident) Cranial Deficits

Neurologic
Hydrocephalus/shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Chronic Disorder
Seizure Disorders

Secondary Concerns
Behavior Problems
Age under Two Years
Age Two - Four Years
Indwelling Catheter
Acute Exacerbation of Paralysis due to Spinal Cord Injury

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 program at the address/phone below. Please fax or mail the forms back once completed.

Sincerely,

Cassie Brunson

Phone: 662-325-1718 Cell: 601-668-8678 Fax: 662-325-8188
229 Lloyd Ricks Watson
Box 9745
Mississippi State, MS 39762

For individuals with **Down syndrome: Neurological Symptoms for Atlantoaxial Instability must be documented: Present☐ Absent☐

The following medical information above must be evaluated and documented by your or your child's physician.

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the MSU Extension EAAT program staff will assess the medical information above against the existing precautions and contradictions. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementation of an effective equestrian program.

Physician Name(please print)_____

PhysicianSignature_____Date:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____