People & Animal Learning Services (PALS)

CLIENT APPLICATION

(To be completed in pen by participant, parent, or legal guardian)

Application Date: _____ /_____ /_____ ❑ New Client ❑ Annual Update

PARTICIPANT CONTACT INFORMATION:

Participant Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name (optional): _____ D.O.B. _____ /_____ /_____

Has the participant been diagnosed with a medical condition? ❑ Yes ❑ No

Primary Diagnosis_____ Secondary_____

Age: _____ Height: _____ Weight: _____ Gender: ❑ Male ❑ Female ❑_____

Mailing Address: _____

City: _____ State: _____ Zip: _____ County of residence_____

Email: _____ Preferred Method of Contact: ❑ Phone Call ❑ Email ❑ Text

Primary Phone: _____ ❑ Home ❑ Work ❑ Cell

Alternate Phone: _____ ❑ Home ❑ Work ❑ Cell

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Who should we contact for scheduling changes or questions (i.e. inclement weather on day of lesson)?

Name_____ Phone_____

IF APPLICANT IS A MINOR AND/OR DEPENDENT:

Parent/Legal Guardian/Caregiver Full Name: _____

Relationship to Applicant: ❑ Father ❑ Mother ❑ Caregiver ❑ Other: _____

Address: (if different than above) _____ City: _____ State: _____ Zip: _____

Email: _____ Cell: _____

Alternate Phone Number: _____ ❑ Home ❑ Work

GENERAL INFORMATION:

Employer / School (if applicable): _____

How did you learn about PALS? (new clients only) _____

People & Animal Learning Services (PALS)

HEALTH HISTORY: Please describe the participant's current health status. Address fitness, cardiac, respiratory, bone / joint function, recent hospitalization/surgeries, or lifestyle changes.
****NOTE** Participants with a diagnosis must obtain a signed physician's statement (included in this packet).**

_____

_____

What medications are you/the participant currently taking, including over-the-counter medications?

_____

_____

Date of last tetanus shot _____

Are you currently under the care of a therapist? ❑ PT ❑ OT ❑ Speech ❑ Mental Health ❑ None
****If yes, please have the enclosed Therapist Information Sheet completed by him/her****

Social / Behavioral Strengths & Weaknesses

_____

_____

Goals (i.e. Why are you/the participant applying for participation in the program? What would you/participant like to accomplish?)

_____

_____

Likes & Dislikes

_____

_____

Suggestions for helping the participant succeed when facing challenges

_____

_____

I understand that the information provided above is accurate to the best of my knowledge. I know of **no** reason why I/this participant **cannot** participate in activities at this therapeutic equine center.

Signature_____ Date _____ /_____ /_____
(Client or Legal Guardian if Participant is a Minor)

POLICY OF CONFIDENTIALITY: Confidentiality is defined as "told in secret or private relations; trusted." Any information in regards to the participants at People and Animal Learning Services, Inc. must be held in strict confidentiality. It is critical that we respect each individual. Confidentiality is considered one of the most basic responsibilities of our facility. In failure to abide by this policy, the quality of the services we provide may diminish and result in legal ramifications. I have read and understand People and Animal Learning Services' Policy of Confidentiality and agree to abide by it.

Signature_____ Date _____ /_____ /_____
Client (or Legal Guardian if Participant is a Minor)

People & Animal Learning Services (PALS)

LIABILITY RELEASE

(If party is a minor or ward, this form to be completed in **ink** by parent or legal guardian)

Witness this release dated this _____ **day of** _____**, 20**____**,** by and between People and Animal Learning Services, Inc., an Indiana not-for-profit corporation, (hereinafter referred to as "Management"), the owner and operator of the stables, riding arena and real estate located at 7644 W. Elwren Road, Bloomington, IN 47403 (hereinafter, collectively, the "Riding Facilities") and _____**, (**hereinafter referred to as "User") **and, if User is a minor or ward, User's parent or guardian,** _____ (hereinafter referred to as "Guardian") (User and Guardian are hereinafter sometimes referred to as "Participant")**.** For valuable consideration received, and in exchange for the covenants and representations herein made, Management, on behalf of itself, its instructors, employees, Board of Directors, Advisory Board, therapists, aides, volunteers, drivers and/or agents (collectively hereinafter referred to as "PALS") and User, Guardian (if applicable), Participants' heirs, assigns, and/or representatives, hereby agree as follows:

1) THE PARTICIPANT AGREES TO ASSUME ANY AND ALL RISKS INVOLVED IN OR ARISING FROM OR RELATED TO USER'S USE OF THE RIDING FACILITIES OR PRESENCE UPON THE RIDING FACILITIES, USE OF HORSES AND EQUIPMENT PROVIDED BY PALS WHETHER ON OR OFF OF THE RIDING FACILITIES, AND ANY RELATED APPURTENANCES, FACILITIES OR EQUIPMENT LOCATED THEREON, INCLUDING, BUT NOT LIMITED TO THOSE RISKS WHICH MAY ARISE FROM OR IN CONNECTION WITH THE NEGLIGENCE OF PALS. PARTICIPANT ACKNOWLEDGES THAT THESE RISKS INCLUDE, BUT ARE NOT LIMITED TO, DEATH, BODILY INJURY OR PROPERTY DAMAGE DUE TO FALLS, KICKS, BITES, COLLISIONS, BEHAVIOUR OF OTHER HORSES, FIRE, EXPLOSION, AND LIMITED EMERGENCY MEDICAL CARE AVAILABILITY.

2) Participant acknowledges that horses, by their very nature are unpredictable and may act upon instinct, fright or whim. Participant assumes all risks in connection therewith and expressly waives any claims for any injury, damage or loss arising therefrom. Participant agrees to abide by and follow PALS' instructions, rules and regulations. Participant further acknowledges that the behavior of any animal is contingent to some extent upon the ability of the User. Participant assumes all risks therefore and warrants a full and fair disclosure of User's abilities have been made to Management. Participant affirms that participant has been well advised and thoroughly informed of the risks and inherent dangers of horseback riding and being in the presence or horses in general.

Participant agrees to assume any and all risks involved in or arising out of Participant's use of any equipment or livestock pertaining to the rental and riding of horses or riding lessons, the use of any equipment, arena or other structure on or about Riding Facilities, the use of any trail on or about the Riding Facilities or related to any and all riding lessons whether provided at the Riding Facilities or off of the Riding Facilities.

_____ Initials

A PATH Intl. Premier Accredited Center

PO Box 1033 | Bloomington, IN 47402 | 812.336.2798 | 866.800.2965 fax | www.palstherapy.org | info@palstherapy.org

3) PARTICIPANT AGREES TO RELEASE, DISCHARGE, HOLD HARMLESS, INDEMNIFY AND DEFEND PALS FROM AND AGAINST ANY AND ALL CLAIMS, DEMANDS, CAUSES OF ACTION, DAMAGES, JUDGMENTS, ORDERS, COSTS OR EXPENSES, INCLUDING REASONABLE ATTORNEY'S FEES, WHICH MAY IN ANY WAY ARISE FROM OR BE IN ANY WAY CONNECTED WITH PARTICIPANT'S USE OF OR PRESENCE UPON THE RIDING FACILITIES OR USE OF HORSES AND EQUIPMENT PROVIDED BY PALS WHETHER ON OR OFF OF THE RIDING FACILITIES, WHETHER OR NOT ARISING FROM THE NEGLIGENCE OF PALS OR ANY THIRD PARTY.

4) PARTICIPANT HAS CAREFULLY READ AND UNDERSTANDS THIS CONTRACT AND AGREES WITH ITS CONTENTS.

UNDER INDIANA LAW, AN 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.

THIS IS A RELEASE OF LIABILITY. DO NOT SIGN IF YOU DO NOT UNDERSTAND OR AGREE WITH ITS TERMS.

Participant Name: _____ Phone_____
(Printed)

Parent/Guardian's Name: _____
(if User is a minor or ward) (Printed)

Participant Full Address (Street, City, State)_____

Participant Signature _____ Date_____

Signature_____ Date_____
(Parent/Guardian if User is a minor or ward)

*** If rider is a guest, please identify boarder responsible: _____**

A PATH Intl. Premier Accredited Center
PO Box 1033 | Bloomington, IN 47402 | 812.336.2798 | 866.800.2965 fax | www.palstherapy.org | info@palstherapy.org

People & Animal Learning Services (PALS)
CONSENT, RELEASE AND ASSIGNMENT

_____, hereinafter referred to as Assignor (if Assignor is a minor, Assignor's parent or legal guardian, _____) hereby consents to the use of, and hereby releases and assigns to People & Animal Learning Services, Inc., an Indiana not-for-profit organization ("PALS") all rights Assignor may now have, or may hereafter acquire, in and to Assignor's name, voice, signature, any images, likenesses, photographs, distinctive appearance, gestures, mannerisms, motion pictures, video recordings, audio recordings and/or writings attributable to Assignor provided to PALS, at any time, in connection with the production or reproduction of any marketing/promotional or educational communications or materials, including but not limited to Assignor's name, voice, signature, any images, likenesses, photographs, distinctive appearance, gestures, mannerisms, motion pictures, video recordings, audio recordings and/ writings attributable to Assignor.

Assignor hereby authorizes PALS to reproduce, copy, exhibit, publish or distribute Assignor's name, voice, signature, any and all such images, likenesses, photographs, distinctive appearance, gestures, mannerisms, motion pictures, video recordings, audio recordings and/or writings attributable to Assignor, on a not-for-profit basis, for as long as deemed beneficial or necessary to PALS, in the sole discretion of PALS.

Assignor understands and agrees that PALS, and/or any officer or director thereof, will be held free and clear of any responsibility or claim for liability in connection with PALS' reproduction, copying, exhibition, publication or distribution of Assignor's name, voice, signature, any and all such images, likenesses, photographs, distinctive appearance, gestures, mannerisms, motion pictures, video recordings, audio recordings and/or writings attributable to Assignor.

****

Please select and initial only one (1) option below.

_____ I hereby certify that I am the person named as Assignor above, I am over the age of eighteen (18), I am of sound mind, and I have read and clearly understand this authorization, and do freely sign this authorization.

_____ I hereby certify that I am the parent or legal guardian of _____, named as Assignor above, that I am legally authorized to sign this authorization on his/her behalf as said person's parent or legal guardian, and, I have read and clearly understand this authorization, and do freely sign this authorization.

_____ I DO NOT consent to the above written Consent, Release and Assignment

_____ _____

Printed Name Signature

_____

Date

PO Box 1033 | Bloomington, IN 47402 | 812.336.2798 | 866.800.2965 fax | www.palstherapy.org | info@palstherapy.org

People & Animal Learning Services (PALS)
MEDICAL AUTHORIZATION FOR EMERGENCY TREATMENT

IMPORTANT: Please read contents carefully and elect only ONE (1) of the options below by initialing. If you elect to permit authorization of emergency treatment, all of Section 2 must be completed. This form must be signed and dated, regardless of election.

To Be Completed for Participants over the age of 18 only:

1. _____ Initial — I, _____ (Print Name), **DO NOT** give permission to People & Animal Learning Services, Inc., an Indiana nonprofit corporation ("PALS") to authorize any emergency treatment.

2. _____ Initial — I **PERMIT** THE AUTHORIZATION OF EMERGENCY TREATMENT AS FOLLOWS:

I, _____, hereby give permission to People and Animal Learning Services, Inc., an Indiana nonprofit corporation ("PALS"), in my absence, to authorize any and all emergency treatment, deemed necessary by PALS, to be performed by any appropriate health care. This authorization shall be effective beginning immediately, and remain effective unless revoked by me in writing. A copy of this document shall have the same effect as the original.

To Be Completed for Participants who are minors/wards only:

_____ Initial — I, _____ (Print Parent or Legal Guardian's Name), as a parent or legal guardian of _____ (Name of Child or Ward), a minor, **DO NOT** give permission to People and Animal Learning Services, Inc., an Indiana nonprofit corporation ("PALS"), in my absence, to authorize any and all emergency treatment to _____ (Name of Child or Ward).

_____ Initial — I **PERMIT** THE AUTHORIZATION OF EMERGENCY TREATMENT, IN MY ABSENCE, AS FOLLOWS:

I, _____, as parent or legal guardian of _____ (Name of Child or Ward), a minor, hereby give permission to People and Animal Learning Services, Inc., an Indiana nonprofit corporation ("PALS"), in my absence, to authorize any and all emergency treatment deemed necessary by PALS, to be performed by a any appropriate health care provider, to _____ (Name of Child or Ward), whose date of birth is _____. This authorization shall be effective beginning immediately, and remain effective unless revoked by me in writing. A copy of this document shall have the same effect as the original.

Printed Name of Participant	Signature of Participant (if over 18)
Printed Name of Parent/Legal Guardian (Minor/Ward only)	Signature of Parent/Legal Guardian (Minor/Ward Only)
Physician's Name	Medical Facility
Health Insurance Company	Policy #

Allergies to medications_____

Current medications_____

Emergency Contact

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

People & Animal Learning Services (PALS)

CLIENT MEDICAL HISTORY & PHYSICIAN'S STATEMENT

****For Participants with a Diagnosis Only****

Give this page to your physician. Certain physical conditions may cause a precaution or contraindication to unmounted and mounted equine activities. In order to safely serve you, this form must be completed & signed by your physician and mailed (PO Box 1033, Bloomington, IN 47402) or faxed (866.800.2965) to PALS.

Patient Name: _____

Diagnosis/Diagnoses:_____

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

Medications: _____

Seizure Type: _____ Controlled? ☐ Y ☐ N Date of last Seizure _____

Special Precautions/Needs:_____

Mobility (check all that apply): ☐ Independent ☐ Assisted ☐ Wheelchair

☐ Braces/Assistive Devices (please specify): _____

PLEASE INDICATE CURRENT OR PAST DIFFICULTIES IN THE FOLLOWING SYSTEMS/AREAS, INCLUDING SURGERIES:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			

	Y	N	Comments
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other:			

PLEASE INDICATE ANY PRECAUTIONS AND CONTRAINDICATIONS (SELECT ALL THAT APPLY)

Medical/Psychological

- ☐ Allergies
- ☐ Animal Abuse
- ☐ Physical/Sexual/Emotional Abuse
- ☐ Blood Pressure Control
- ☐ Dangerous to self or others
- ☐ Exacerbations of medical conditions
- ☐ Fire Setting
- ☐ Heart Conditions
- ☐ Hemophilia
- ☐ Medical Instability
- ☐ Migraines
- ☐ PVD
- ☐ Respiratory Compromise
- ☐ Recent Surgeries
- ☐ Substance Abuse
- ☐ Thought Control Disorders
- ☐ Weight Control Disorder

Orthopedic

- ☐ Atlantoaxial Instability (include neurological symptoms)

  _____

  _____
- ☐ Coxa Arthrosis
- ☐ Cranial Deficits
- ☐ Heterotopic Ossification/Myositis Ossificans
- ☐ Joint subluxation/dislocation
- ☐ Osteoporosis
- ☐ Pathologic Fractures
- ☐ Spinal Fusion/Fixation – indicate vertebrae:

  _____
- ☐ Spinal Instability/Abnormalities

Neurological

- ☐ Hydrocephalus/Shunt
- ☐ Seizure
- ☐ Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia
- ☐ Spinal Cord Injury Above Thoracic 6 Vertebrae

Other

- ☐ Age – Under 4 years old
- ☐ Indwelling Catheters
- ☐ Medication – i.e. photosensitivity
- ☐ Poor Endurance
- ☐ Skin Breakdown
- ☐ Other:_____

To my knowledge, there is **no reason** why this person **cannot** participate in supervised equestrian activities. I understand that the therapeutic riding 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 in the implementations of an effective equestrian program.

Name (PRINTED)_____ ☐MD ☐DO ☐NP ☐PA ☐Other_____ License#_____

Signature_____ Date_____ Phone_____

People & Animal Learning Services (PALS)

CLIENT THERAPIST INFORMATION SHEET

OPTIONAL

Instructions: Please give this form to the PT/OT/SP (or other) with whom the participant is working on a regular basis. This information is helpful for our instructors.

Client Name: _____

Diagnosis/Diagnoses: _____

School/Program: _____

PLEASE ANSWER THE FOLLOWING IN TERMS OF GOALS/OBJECTIVES ETC. THAT YOU ARE STRIVING TO ACHIEVE WITH THE CLIENT/STUDENT.

Brief History and Muscle Evaluation:_____

_____

Short Term Goals: _____

_____

Objectives: _____

_____

Long Term Goals: _____

_____

Degree of Coordination: _____

_____

Areas of Strength: _____

_____

Any Precautions: _____

_____

Behavior: _____

_____

Joint Evaluation: _____

_____

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

Wheelchair ☐ Y ☐ N Capable of Independent Sitting with Support? ☐ Y ☐ N

Therapist Signature: _____ Date: _____

Printed Name (Therapist): _____ Phone:_____

A PATH Intl. Premier Accredited Center

PO Box 1033 | Bloomington, IN 47402 | 812.336.2798 | 866.800.2965 fax | www.palstherapy.org | info@palstherapy.org