

# Sierra Therapeutic Equestrian Program, Inc.



1680 Sandra Lane  
Minden, Nevada 89423

Cell: (775) 721-5677  
email: HomeMeansNevada2@aol.com  
www.SierraTEP.org

## Participant's Application and Health History

### GENERAL INFORMATION

Participant: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender:  M  F

Address: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W/C) \_\_\_\_\_ Email: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Phone: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W/C) \_\_\_\_\_

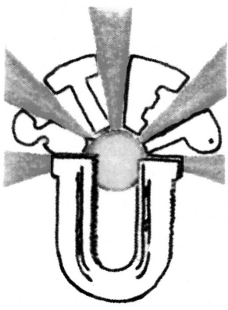
How did you hear about the program? \_\_\_\_\_

### HEALTH HISTORY

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

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

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			



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## Authorization for Emergency Medical Treatment Form

Participant    Staff    Volunteer

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Current medications: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

In the event 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 STEP, Inc. 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.

### Consent Plan

This authorization includes x-ray, 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 unable to be reached.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_

Client, Parent or Legal Guardian  
*Signed in the presence of center staff*

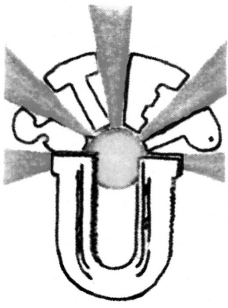
### Non-Consent Plan

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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_

Client, Parent or Legal Guardian  
*Signed in the presence of center staff*



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### Photo Release

I (check one:)  Do /  Do Not consent to and authorize the use and reproduction by Sierra Therapeutic Equestrian Program, Inc. (STEP, Inc.) of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Client, Parent or Legal Guardian  
(Signed in the presence of STEP, Inc. staff.)

### Liability Release

\_\_\_\_\_ (Rider's name) would like to participate in the STEP, Inc. program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself, my son/daughter or my ward are greater than the risk assumed. I, hereby, intend to be legally bound for myself, my heirs and assigned executors or administrators. I waive and release, forever, all claims for damages against STEP, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or employees for any and all injuries and/or losses I, my son/daughter or my ward may sustain while participating in the STEP, Inc. program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Client, Parent or Legal Guardian  
(Signed in the presence of STEP, Inc. staff.)