



PARTICIPANT APPLICATION

811 Pemberton Hill Road, Building 4
Dallas, TX 75217



This information must be updated and submitted annually.

Client Name: _____ Date of Birth: _____ Gender: _____
Street: _____
City: _____ County: _____ State: _____ Zip Code: _____
Primary Phone: _____ (home/cell/work) Secondary Phone: _____ (home/cell/work)
Email: _____ Preferred Method of Contact (*circle one*): phone email mail
Client School or Employer: _____ School Grade or Occupation: _____

If under age 18 or dependent adult, please list parent/guardian/caregivers names below:

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

In case of emergency, please contact the following if other than parent/guardian/caregiver:

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

Programs of Interest (circle all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Therapeutic Horsemanship Group/Drill Team | <input type="checkbox"/> Occupational Therapy - Equine Assisted |
| <input type="checkbox"/> Therapeutic Horsemanship Semi-Private | <input type="checkbox"/> Physical Therapy - Equine Assisted |
| <input type="checkbox"/> Therapeutic Horsemanship Private/Driving | <input type="checkbox"/> Hooves for Heroes (Veterans) <i>*no charge if requirements met</i> |

Referral Method

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Equest Client | <input type="checkbox"/> Equest Volunteer | <input type="checkbox"/> Veteran Service Org | <input type="checkbox"/> Medical Referral |
| <input type="checkbox"/> Family/Friend | <input type="checkbox"/> Equest Website | <input type="checkbox"/> Other: _____ | |

Military Information

- | Service Status | Service Branch | Military Family | Service Era |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Active | <input type="checkbox"/> Air Force | <input type="checkbox"/> Child | <input type="checkbox"/> Post 9/11 |
| <input type="checkbox"/> Retired | <input type="checkbox"/> Army | <input type="checkbox"/> Spouse | <input type="checkbox"/> Cold War |
| <input type="checkbox"/> Discharged | <input type="checkbox"/> Coast Guard | <input type="checkbox"/> Surviving Child | <input type="checkbox"/> Desert Storm |
| <input type="checkbox"/> Reservist | <input type="checkbox"/> Marine | <input type="checkbox"/> Surviving Spouse | <input type="checkbox"/> Vietnam |
| <input type="checkbox"/> First Responder | <input type="checkbox"/> National Guard | <input type="checkbox"/> Caregiver | <input type="checkbox"/> Korea |
| <input type="checkbox"/> Not Applicable | <input type="checkbox"/> Navy | <input type="checkbox"/> Not Applicable | <input type="checkbox"/> World War II |
| | <input type="checkbox"/> Other: _____ | | |

We ask for your **voluntary** response to the following questions as we grow and expand our services. This information will be used **ONLY** for purposes of fund-raising, obtaining financial and in-kind support from foundations and other support agencies as well as from government entities. Your response will, in no way, influence your registration or participation at Equest.

- Total Household Income:** ___ less than \$24,999 ___ \$25,000-\$45,999 ___ \$46,000-\$69,999 ___ more than \$70,000
- Client Race/Ethnicity (check all that apply):** ___ American Indian or Alaskan Native ___ Black or African American ___ Asian
___ Native Hawaiian/other Pacific Islander ___ Hispanic or Latino ___ White

Required signature of client or parent/guardian of dependent client

Date

Client Name: _____

Photo Release

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to Equest permission to take, or have taken, still and moving photographs and films of the above named Client, including television pictures, and consents and authorizes Equest, its advertising agencies, news media, and any other persons interested in Equest and its work, to use and reproduce the photographs, films or pictures, and to circulate and publicize the same by all means, including, without limiting the generality of the foregoing, newspapers, television media, brochures, pamphlets, instructional materials, books, and clinical materials. **Please note that your presence or participation in a public event at Equest or event involving Equest constitutes a tacit waiver of this non-consent. Electing the non-consent option will not necessarily prevent a subject from being photographed or filmed at any such event by Equest or the general public.**

With respect to the foregoing matters, no inducements or promises have been made to secure this signature to this release other than the intention of Equest to use, or cause to be used, such photographs, films, and pictures for the primary purpose of promoting Equest and its work.

Please check one of the boxes:

Consent

Do Not Consent

For the safety of our clients, horses, and volunteers, we adhere to our veterinarian's recommendations for height to weight ratios listed here. If you are outside the height to weight ratios, accommodations can be made at the discretion of the Program Director.

Under 5'0" tall = 150lbs

5'0"-5'6" = 175lbs

5'7"-6'0" = 200lbs

6'1"-6'5" = 250lbs

Please check the box as acknowledgment of the height to weight ratio:

I have read and understand the Equest No Show and Cancellation Policies. (Please see page 7 for policies)

Release of Liability

This section of the page is required to participate in all activities and must be updated annually.

Equest, its officers, members, employees, and agents (including volunteers) will not be responsible for any damages to person, animal or property at the Equest Therapeutic Horsemanship Center or its grounds, nor will they be responsible for any property lost or destroyed. The undersigned Client or parent/guardian hereby releases Equest, its officers, members, employees, and agents from any and all liability and claims of any nature whatsoever, **including taking action to control, restrain, or confine the undersigned, for the safety or protection of the undersigned or others** and any damages whatsoever (including costs, expenses, and attorney's fees) that might result from damages, injuries, or losses to their person or property during, or in connection with, or arising out of, any class, lesson, demonstration, show, clinic, event or other function, **WHETHER OR NOT SUCH DAMAGES, INJURIES, OR LOSSES RESULT DIRECTLY OR INDIRECTLY FROM THE NEGLIGENT ACT OR OMISSION OR OF ANY INTENTIONAL OR WILLFUL ACT OR TORT OF SUCH RELEASED PARTIES OR OF ANY INVITEE OF ANY RELEASED PARTY.**

WARNING: UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTICE AND REMEDIES CODE), AN EQUINE PROFESSIONAL IS NOT LIABLE FOR ANY INJURY TO, OR THE DEATH OF, A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES.

In exchange for the use of property owned by Equest and other valuable consideration, I agree that my use of premises and any animals, facilities, or equipment owned by Equest is at my own risk. I further agree to indemnify and hold harmless Equest, and its respective officers, members, employees, and agents, from any and all suits, actions or claims of any type arising from my use of the premises or participation in an equine activity, or of such use or participation by my guest, whether or not such claims result directly or indirectly from the negligent act or omissions of the indemnified parties or otherwise.

I acknowledge involvement with horses is a high-risk activity.
I have read this agreement and fully understand its content.

Required signature of client or parent/guardian of dependent client

Date



Medical and Client History (Part 1 of 2)



*This form must be updated annually and submitted with required signatures.
All forms must have required signatures and be returned to Equest prior to participating.*

Client Name: _____ Date of Birth: _____

Height: _____ feet _____ inches Weight: _____ lbs Gender: _____

Primary Diagnosis: _____ ICD Code: _____

Diagnosis ONSET (please check one): Birth Childhood Adolescence Adulthood Date: _____

Secondary Diagnosis: _____ Tertiary Diagnosis: _____

Client is (check all that apply): Verbal Hearing Ambulatory Seeing
 Verbal Assisted Hearing Assisted Ambulatory Assisted Seeing with assist
 Non-Verbal Deaf Non Ambulatory Blind

PLEASE LIST ALL CURRENT MEDICATIONS:

1. _____ Taken for: _____
2. _____ Taken for: _____
3. _____ Taken for: _____
4. _____ Taken for: _____

CURRENT/PREVIOUS THERAPIES:

OT: _____
 PT: _____
 Speech: _____
 Other: _____

EQUEST GOALS for IMPROVED DAILY LIVING SKILLS:

Please include equestrian skills and daily living skills

1. _____
2. _____
3. _____
4. _____
5. _____

Hobbies and other interests: _____

Riding Experience:

New to Equest? Yes No First year at Equest: _____ Other equine therapy facility: _____

Previous riding or horse-related experience: None Minimal Moderate Extensive

If previous riding experience: Independent Spotter/Leader Side-walker(s)

Describe previous equine experience: Year started: _____ Duration: _____ Notes: _____

Required signature of client or parent/guardian of dependent client

Date



Medical and Client History (Part 2 of 2)



Please indicate if the client has or has had a history of the following by checking yes or no.

Client Name: _____

Date: _____

Concern	Yes	No	If Yes, please describe
Allergies			
Asthma/COPD			
Auditory			
Brace			Last X-Ray Date: _____
Cardiac			
Circulatory			
Dislocating Joints			
Laminectomy/Fusion			
Learning Disability			
Mental Impairment			
Neurological			
Ossification			
Osteoporosis			
Pain			
Psychological Impairment			
Scoliosis			Degree: _____ Type: _____
Seizures Type: _____			Controlled: <input type="checkbox"/> Yes <input type="checkbox"/> No Last Seizure Date: _____
Skeletal			
Speech Impairments			
Spinal Column Injury			
Spondylolisthesis			
Subluxing Joints			
Surgical Implants			
Visual Impairment			
Other			
Mobility:			
Independent Ambulation?			
Cane/Crutches/Walker			
Prosthetics			
Orthotics			
Wheelchair			



Physician's Release



To be completed by participant's physician.
This form must be updated annually and submitted with required signatures.

Physician, please note - the conditions noted on the accompanying medical history, if present, may represent precautions or contraindications to equine assisted activities. Therefore, when reviewing the medical history, please note whether these conditions are present and to what degree. Please be as specific as possible so that we may best serve the client's needs.

Equest will make the final determination about an individual's ability to participate in the program.

Patient Name: _____ Date of Birth: _____
Patient Primary Diagnosis: _____ ICD 10 Code: _____
Secondary Diagnosis: _____ Other: _____
Height: _____ Weight: _____
Specific limitations not noted on the medical history: _____

ALL Participants with Down Syndrome - PLEASE NOTE:

Due to the nature of Equine Assisted Activities and Therapies, we require that ALL individuals diagnosed with Down Syndrome must have an ANNUAL certification from their physician that a neurological and/or physical examination reveals no sign of AAI or decrease in neurological function:

- A) **Annual** neurological/physical exam for AAI/decreased neurological function: Positive Negative Exam Date: _____
- B) Most recent cervical x-ray for AAI: Positive Negative X-Ray Date: _____

I have reviewed the attached medical history and release my patient to participate in appropriate programming at Equest. I am aware and permit my patient to actively participate in the following areas (*check all that apply*):

Sitting astride a horse: Yes No Driving a carriage: Yes No
Grooming horses: Yes No Other equine related ground activities: Yes No

Given the above diagnosis and medical information, I affirm that this person is not medically precluded from participating in supervised equine-assisted activities. I understand that Equest instructors and therapists will weigh all medical information against any precautions and contraindications. Therefore, I refer this person to Equest for ongoing evaluation to determine further eligibility for participating in supervised equine-assisted activities.

Physician Name: _____ MD DO NP PA Other: _____
License/UPIN #: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Office Phone: _____ Office Fax: _____
Physician's Signature: _____ Date: _____

When completed with ALL SIGNATURES please return this form to:

Equest
PO Box 171779, Dallas, TX 75217
Phone: (972)412-1099 | Fax: (972)947-3940



Physician's Prescription Form



To be completed by participant's physician for PT/OT Only.
Please provide BOTH Diagnosis and ICD 10 Code - incomplete forms will be returned.

Client Name: _____

Date of Birth: _____

Primary Dx: _____

ICD 10 Code: _____

Secondary Dx: _____

ICD 10 Code: _____

Clinical Comments:

Evaluate and treat, to include Physical Therapy Occupational Therapy as a treatment tool.
Frequency: Treatment as needed based on Therapist evaluation.

This prescription will be current for one year (12 months) from date of Physician's Signature.

Physician Name: _____ MD DO NP PA Other: _____

License/UPIN #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Office Phone: _____ Office Fax: _____

Physician's Signature: _____ Date: _____

When completed with ALL SIGNATURES please return this form to:

Equest
PO Box 171779, Dallas, TX 75217
Phone: (972)412-1099 | Fax: (972)947-3940



Equest No-Show and Cancellation Policy



We ask that the following policies be adhered to so that we may be able to offer the best quality program possible.

- 1) Please arrive a few minutes early for your class. This will give you a chance to use the restroom, find and put on your helmet, and be ready to mount on time. It may not be possible to mount a late arrival and if the arena gate is closed and the class has already started, then you will not be able to ride that day.
- 2) We will consider you “absent” if you have notified us at least 24 hours in advance. Otherwise, we will consider you a “no-show.”
- 3) If you will be absent, please call (972)449-1299 and **PLEASE LEAVE A VOICEMAIL** clearly stating the client’s name, class day, and class time.
- 4) In the case of an emergency, the client or parent/guardian should call within 24-48 hours **after** the emergency.
- 5) In the case of sudden illness, the client or parent/guardian should call as soon as it is apparent that they will not be able to attend due to illness (at least 2 hours prior to the lesson time).
- 6) Excessive absences (3 or more) or no-shows (more than 1) will be subject to losing your class slot and being placed at the end of the waiting list.
- 7) Clients who have been awarded a scholarship for the semester and do not follow our cancellation procedures will be subject to forfeiting the scholarship and being ineligible for future scholarships. Scholarship clients may also be subject to a **“no-show” fee of \$25.**
- 8) Clients participating under agency funding through the State and do not follow our cancellation procedures will be subject to a **“no-show” fee of \$25** and will be billed personally.
- 9) There will be **NO REFUNDS** or make-up for missed classes unless Equest must cancel due to weather or scheduling conflicts. Payment for the semester is required before the semester begins.
- 10) If you must withdraw from the semester after it has begun, please contact Angela Escamilla, Registrar, aescamilla@equest.org or (972)412-1099 ext. 209.

“No-Show, No-Calls” result in:
Decrease in recruiting and retaining volunteers
Unnecessary tacking and untacking of our horses
Inefficient use of staff and volunteers

Additional Information for Physical/Occupational Therapy Clients

We require a **minimum of 2 hours’ notice** for the cancellation of a therapy appointment. Cancellations made less than 24 hours in advance may be considered a “no-show” and subject to a **cancellation fee of \$35.**

Cancellations made for reasons that could be rescheduled for another time, such as other therapies, doctor appointments, and vacations must be turned into your therapist a minimum of 2 weeks prior to the absence.



Equest Riding Levels and Program Information



Therapeutic Horsemanship

Equest's Therapeutic Horsemanship classes are organized to assign riders to a class according to age and level of riding skill. We periodically re-define rider levels so as to best meet our riders' abilities. The following descriptions are provided to help riders select the appropriate class. The Director of Program Quality and Development and the Instructors will determine final placement of riders.

- * Group lessons are 60 minutes and may have up to 6 clients per class.
- * Semi-Private lessons are 45 minutes and have 2 clients per class.
- * Private Lessons are one-on-one and are 45 minutes in length.
- * Therapeutic Carriage Driving Lessons are currently one-on-one and are 45 minutes in length.

Riding Levels

- Level 1** For riders who are NEW to Equest or who require direct assistance at the WALK and/or TROT.
- Level 2** For riders who are emerging walk and/or trot independent. Riders at this level can ride for SHORT distances without anyone holding the lead rope at the TROT.
- Level 3** For riders who have become TOTALLY independent at the walk and trot. Riders at this level will need only a Leader for mounting, warm-up exercises, and dismounting.
- Level 4** For riders who are confirmed independent at the walk and trot and are ready to begin cantering OR are already cantering.
- Level 5** For riders who are confirmed independent at the walk, trot, and canter and are learning how to jump.

Riding Sub-Levels

- A For riders age 4-12
- B For riders age 13+
- C For riders of any age

Hippotherapy

Hippotherapy is either a physical therapy, occupational therapy, or speech therapy session. Hippotherapy uses the movement of the horse to facilitate dynamic posture control for riders with movement dysfunction. Each Hippotherapy rider uses assistance from three volunteers as leaders and side-walkers. Each therapy session is typically 60 minutes.

If you have any questions, please contact: Equest Registrar, Angela Escamilla at (972)412-1099 ext. 209 or registrar@equest.org



How Can I Help Equest?



We ask for your voluntary response to the following questions as we grow and expand our services. This information will be used **ONLY** for purposes of fund-raising, obtaining financial and in-kind support from foundations and other support agencies as well as government entities. Your responses will in now way influence your registration or participation at Equest.

Name: _____ Phone: _____ Email: _____

Equest Affiliation: Client Client Parent/Guardian Volunteer Other: _____

Please indicate any civic or service organizations that you or your family are involved with:

Club/Organization Type	Club/Organization Name
Rotary Club	
Lions Club	
Junior League	
Exchange Club	
Religious Organization	
Military or Retired Military Organization	
Service Organization	
Other	

Please indicate the employment of you and/or your family:

Who	Employer	My Employer Offers:		
		Matching Gifts	In-kind Donations	Sponsorships
You		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse/Partner		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Member		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Member		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I would like to share my story as part of an Equest Ambassador Yes No

I am fluent in a language other than English Yes No Language: _____

I would like to share my talents Photography Database Handyman Other: _____

I would like to volunteer for a committee Gala Ridefest Boots & Salutes Angel Tree

I would like more information about Women's Auxiliary Carrot Club Other opportunities

I would like to sponsor an Equest Horse (**\$5,000 annually**): _____ (name of Horse)

I have media connections Yes No

I have a suggestion for one of the following and would like to be contacted:

- Donor Sponsor In-kind Donation Community Partnership Corporate Partnership
 Grant Horse Other: _____