Milestones, Inc
Equestrian Achievement Program

Milestones therapeutic horsemanship program presents opportunities for individuals with challenges to enhance their quality of life.

Milestones Student Registration Form

Please fill out all requested information.

Student name:_____ Height:_____Weight:_____

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

School/Occupation:_____Current Grade:_____Birthdate: _____

Is the student his or her own legal guardian? ❑ Yes ❑ No If no provide:_____

Name of Parent/Guardian:_____

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

Occupation:_____ Employer:_____

Occupation:_____ Employer:_____

Contact Information: How can Milestones reach you in a non-emergency; for example to discuss scheduling?

Home #:_____

Work #:_____

Cell#:_____

Email address(es): (Only give address(es) you want used)

Personal:_____Work:_____

Student's primary diagnosis, and any other pertinent information that would aid in a successful equestrian experience:_____

_____

Diagnosis:_____

What do you as a student or parent hope to gain from this equestrian experience? _____

_____

_____

12372 Riggs Road, Independence, KY 41051
Phone/fax 859.694.7669 (phone/fax) www.milestonesinc.org

Student Release Form
Photo Release
Confidentiality Policy

Photo Release - I consent to and authorize the use and reproduction by Milestones, 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 Milestones, Inc.

Date_____ Signature (Student, parent or guardian)_____

Confidentiality Policy – For the effectiveness and safety of the equestrian program, I understand that information pertaining the rider's medical condition(s) is shared with volunteers on a need-to-know basis. All information remains confidential. I support this policy

Date_____ Signature (Student, parent or guardian) _____

Consent & Waiver - WARNING. Under Kentucky law, a farm animal activity sponsor, farm animal professional or other person does not have the duty to eliminate all risks of injury of participation in farm animal activities. There are inherent risks of injury that you voluntarily accept if you participate in farm animal activities.

I hereby request that the participant named above be accepted into the riding program operated by Milestones, Inc. I acknowledge that Milestones, Inc. has fully explained to me the scope of the riding program, including the potential for serious injury which can occur from riding, caring for and being around horses and farms.

Because of the potential benefits of Milestones, Inc.'s equestrian programs, I agree to waive any claim which the above named participant or anyone accompanying the participant may have against Milestones, Inc., its employees and volunteers and to release them from any liability or responsibility for accident, damage, injury, or illness caused to the undersigned or to any family member or guest accompanying the undersigned on the premises, including, but not limited to, those caused by horses or physical conditions of this farm.

Date_____ Signature (Student, parent or guardian)_____

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Milestones Authorization for Emergency Medical Treatment Form

Please fill out all requested information.

Student name:_____ DOB:_____

In case of emergency, please contact:

Name/Relationship Day Phone Evening Phone Other Phone

_____

_____

_____

In the event of an emergency and the emergency contact(s) cannot be reached, please initial one of the following plans and complete the information:

_____ **Consent Plan**

In the event of an emergency and the emergency contact(s) cannot be reached, I authorize Milestones, Inc. to make health care decisions with respect to the student named.

Date:_____ Signature (student, parent or guardian):_____

Physician's name:_____ Phone:_____

Preferred Medical Facility: _____

_____ **NON-Consent Plan - I do NOT consent to Milestones, Inc. making healthcare decisions concerning the student**

If the undersigned does NOT desire to grant Milestones, Inc. authority to make health care decisions for the student if the undersigned in not available, please initial the line before "NON-CONSENT PLAN" and state below the procedures to be followed if the student becomes ill or is involved in an accident:

Date:_____ Signature (student, parent or guardian): _____

Print Name: _____

Day Phone:_____Evening Phone:_____Other Phone:_____

Address: _____

_____

Please return this completed form by mail (original signatures are required)

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Milestones Participant's Medical History & Physician's Statement Form

Please return **original, signed form - no fax or copies accepted**

Participant name:_____ DOB:_____ Height:_____
Address:_____
Diagnosis:_____ Date of Onset: _____
Past/Prospective Surgeries: _____
Medications:_____
Seizure Type:_____ Controlled: Y N Date of Last Seizure: _____
Shunt Present: Y N Date of Last Revision: _____
Special Precautions/Needs: _____

Mobility: Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N Braces/Assistive Devices: _____
For those with Down Syndrome: AtlantoDens Interval X-rays, Date:_____ Result: + –
Neurologic Symptoms of AtlantoAxial Instabilitiy:

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			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

In my opinion, this patient can participate in supervised equestrian activities. I understand that Milestones, Inc. will weigh the medical information above against the existing precautions and contraindications of therapeutic horseback riding. 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.

The patient's weight as of the date of this report is: _____. (Physician initials required)

Physician's Signature:_____ Date:_____

Physician's Name (please print or stamp) _____

Address/City/Zip: _____