Participant Information Sheet

Please fill out this application completely and accurately and return it to MESA
at PO Box 516, Pinedale, WY 82941
or email to subletterides@gmail.com

PARTICIPANT INFO

Name: _____ **Date:**_____
Age: _____ Date of Birth: _____/_____/_____

Male ____ Female ____ Height: _____Weight: _____
Grade Level: _____ School Attending: _____

Address: _____
_____
Primary Phone: _____
Email: _____

Primary Diagnosis: _____
Secondary: _____ Details: _____
_____
_____
_____

Primary language spoken/understood: _____

PARENTGUARDIAN/ INFORMATION

(Only fill out information if different from participant)

Name: _____
Relation: _____
Address: _____
_____
Primary Phone: _____
Alt. Phone: _____
Email: _____

EMERGENCY CONTACT INFORMATION

(If different from Parent/Guardian Above)

Name: _____
Relation: _____
Primary Phone: _____
Alt. Phone: _____
Email: _____

Physical Concerns

_ No concerns (If there are no concerns, skip ahead to next section.

Does the participant have difficulty with the following skills?
Mark with 'X' for yes:

__ Sitting unassisted For how long? _____
__ Standing unassisted For how long? _____
__ Running unassisted
__ Using hands independently
__ Releasing objects
__ Bearing weight on hands
__ Climbing stairs
__ Bearing weight on legs

Have there been any seizures in the last year? Yes ___ No ___

If yes, when? _____
Type of seizure? _____

Describe general balance: _____
_____
Concerns with temperature: _____
_____
Concerns with Pressure sores/ skin breakdown: _____
_____
Shunt/catheters: _____
Concerns with Muscle spasms/tightness: _____
_____
Concerns with Speech: _____
Hand/eye coordination: _____
Is the participant extra sensitive to the sun? Yes ___ No ___
Endurance: _____
Is the participant extra sensitive to hot/cold temperatures?
Yes ___ No ___
Primary means of mobility (i.e. power / manual wheelchair, cane, walker, etc)? _____

Transfers (please circle one):
No Assist Partial Assist Total Assist Not Sure

Behavioral & Emotional Concerns

___ No Concerns (if there are no concerns in the following areas, skip ahead to **Sensory Concerns**)

Does the student have any behavioral or Emotional concerns? _____ Yes _____ No If yes, please explain _____
_____
_____

Does the participant show violence? _____ Yes _____ No If yes, please explain _____
_____
_____

Successful Intervention Strategies used (behavioral, rewards, consequences, etc.):_____
_____
_____

Sensory Concerns

___ No concerns (If there are no concerns, skip ahead to **Cognition/ Processing)**

Please mark applicable concerns below with an 'X':

__Vision:
__ Partially sighted/legally blind
__ Totally blind
Please describe the amount of vision the participant has:
_____
_____

___Hearing:
__ Partial hearing loss
__ Total hearing loss
Please describe how he/she best communicates:
_____
_____

Please describe sensitivities in the following areas:

Visual (seeing): _____
_____
Auditory (hearing): _____
_____
Olfactory (smelling): _____
_____
Tactile (touching): _____
_____
Proprioceptive (movement): _____
_____
What sensory situations upset him/her? _____
_____
_____
Assistive technology used, if applicable: _____
_____

Cognition and Processing

___ No Concerns (if there are no concerns in the following areas, skip ahead to **Medical Information**)

Please check areas of concern or delay.

Educational
__ Knowing numbers
__ Knowing letters
__ Knowing left/right
__ Making Choices
__ Communicating feelings

Social
__ Recognizing own name
__ Making eye contact
__ Waving: says hi/bye
__ Sharing toys/items
__ Knowing safety awareness
__ Interacting with peers
__ Appropriate conversation
__ Taking turns
__ Understanding personal space

Language
__ Making sounds
__ Saying words
__ Combining 2 or more words
__ Speaking in complete sentences
__ Understanding "No"
__ Letter sound identification
__ Signing or uses gestures
__ Uses picture symbols

Follows Directions: ____ 1-step ____ 2-step ____ 3-step ____ Complex
Attention to task: ____ Poor (0-1 min) ____ Fair (1-5 min) ____ Avg (5 min) ____Good
Frustration Tolerance: ____ Poor ____ Fair ____ Average ____Good
Problem Solving: ____ Poor ____ Fair ____ Average _____Good
Learning Style: _____ Visual/learns by seeing _____ Auditory/learns by hearing _____ Kinesthetic/learns by doing

Medical Information

If the participant is taking medication, please list any medications and their side effects that would be important to know during lessons.

_____
_____
_____

Dietary Restrictions

Please list any food restrictions**.**

_____
_____

Allergies

Please list ALL known allergies (foods, environmental, medications, animals, etc).

Allergy	Reaction	Control Techniques/Medications

Personal Care/Independence ___ No Concerns (if there are no concerns in the following areas, skip ahead to **General Info**)

M.ESA does not provide personal care. If the participant needs assistance in the below areas, you will need to provide an aide/caretaker.

Will a care provider be attending the program with the participant? ___ Yes ___ No

Please circle the most appropriate answer:

Toileting:	Independent	Partial Assist	Total Assist
Bladder Control:	Normal	Occasional	Incontinent
Bowel Control:	Normal	Occasional	Incontinence
Dressing:	Independent	Partial Assist	Total Assist

General Information

Favorite activities, hobbies or topics? _____
_____
Favorite Color: _____Favorite TV/Movie Characters: _____
Favorite Music: _____ Favorite Type of Animal or Have Pets? _____
Other Favorite Things / Interests: _____
Any fears or dislikes? _____
_____
Family Do's and Don'ts: _____
_____
_____
Anything else we should know? _____
_____
_____

Has the participant ridden a horse? ___ Yes ___ No If yes, what kind? __ Pony Ride __ Western __ English __ Trail Ride
Please Explain: _____

GOALS - MUST BE COMPLETED!!

What is (are) the participant's Life Goal(s)? _____
_____
_____

What would the participant like to accomplish while at MESA? _____
_____
_____
_____
_____

Recommendation (For New Participants Only):

Name and contact information for counselor/professional who made the recommendation for the participant to join MESA?
_____
_____
_____

M.E.S.A. THERAPEUTIC HORSEMANSHIP, INC.
MESA Equine Assisted Services

EQUINE LIABILITY RELEASE, WAIVER OF RIGHT TO SUE AND ASSUMPTION OF ALL RISKS

This Equine Activity Liability Release, Waiver of Right to Sue and Assumption of All Risks Agreement (the "Agreement") is hereby given by _____ on his/her own behalf OR as the parent or guardian of _____ to M.E.S.A. THERAPEUTIC HORSEMANSHIP, INC., a Wyoming not for profit corporation, as the equine activity sponsor (the "Sponsor"), and to each officer, director, agent, employee, volunteer, equine professional (as defined in the Act referenced herein), instructor, therapist, aide, heir, personal representative, successor and/or assign of the Sponsor (who also shall be included within the word "Sponsor") and agrees as follows:

In consideration for the opportunities provided by the Sponsor to the undersigned, including any minor or legal ward in whose behalf the undersigned signs this Agreement (collectively, the "Participant"), for the enjoyment of equine activities and the use of the Sponsor's facility and equipment, the Participant hereby agrees as follows:

1. This Agreement is given in part within the scope of the Wyoming Recreational Safety Act, Wyoming Statutes § 1-1-121, et seq, and that I and/or the minor participant, assume all inherent risks related to the participation of such recreational activity. All terms defined by the Act shall have the same meaning herein, and the Act is hereby incorporated in this Agreement by reference. This Agreement shall be so construed as to provide to the Sponsor the fullest protection of a release, waiver of claim and recovery, right to sue and assumption of all risks that is afforded by the Act, and by other applicable statutes and general law.

2. The Participant hereby acknowledges that he/she has full and complete notice and understanding of the Act and of all the dangers and/or conditions which are an integral part of equine activities which may cause, contribute to or result in the death or personal injury of the Participant or damage to the Participant's property (the "Risks"), including, but not limited to:

- The propensity of equines to behave in ways (such as, but not limited to, buck, stumble, fall, rear, bite, kick, run, and make unpredictable movements, spook, jump obstacles, step on a person's feet, push or shove a person, saddles or bridles may loosen or break) that may result in injury, harm, or death to persons on or around the equine;
- The unpredictability of an equine's reaction to sounds, sudden movement, persons, other animals, or unfamiliar objects.
- Hazards, including, but not limited to, surface or subsurface conditions;
- A collision with another equine, another animal, a person, or an object;
- The potential of an equine activity participant to act in a negligent manner that may contribute to injury, death, or loss to the person of the participant or to other persons, including, but not limited to, failing to maintain control over an equine or failing to act within the ability of the participant.
- The inability of anyone whomsoever to predict or foresee an equine's reaction to excitement, weather conditions, sound, movements, objects, vehicles, persons, animals, reptiles, birds or insects, and the effects of such reactions.
- The dangers and risks of tack or harness, loosening, slipping or breaking for whatever reason.
- The dangers and risks of becoming entangled in tack, harness, or vehicles used in an equine activity.
- The risks of falling from or otherwise becoming unstable on an equine or a vehicle used in an equine activity for any reason whatsoever or for no identifiable reason.
- Any negligent act or omission by the Sponsor which causes or results in the death or personal injury of the Participant or damage to the Participant's property.

3. The Participant hereby expressly assumes all risks and dangers of injury, loss, damage or death which are in any way resulting from the inherent risks of equine activities and/or associated with the Risks enumerated in paragraph 2 above.

4. The Participant hereby releases and waives all rights which he/she may have or hereafter have against the Sponsor for injury, loss, damage or death which is in any way resulting from the inherent dangers of equine activities and/or associated with the Risks enumerated in Paragraph 2 above, and the right to sue or to bring any action against the Sponsor in connection therewith. The Participant agrees to completely indemnify and hold the Sponsor harmless from and against any and all claims, demands, causes of action, suits, actions, losses, liabilities, costs and/or expenses, including medical costs and attorney's fees, which are occasioned by, or otherwise attributable to, matters for which the Participant has hereby assumed the risk and is responsible in accordance with this Agreement.

5. The Participant agrees to comply with all rules and regulations posted or otherwise communicated by the Sponsor. The Participant agrees that the Sponsor has made reasonable and prudent efforts to determine the Participant's ability to engage in the Equine Activity offered by the Sponsor and the Participant has disclosed all known physical and psychological conditions to Sponsor to assist Sponsor in evaluating the Participant for participation in the Equine Activity offered by the Sponsor.

6. The Participant agrees that mounting, riding, walking, dismounting, grooming, training, handling, feeding, and otherwise being in the physical proximity of horses is a dangerous activity which produces a foreseeable risk of mortal or serious personal injury and/or property loss to the Participant in such activity as well as to the person or property of others.

7. This Agreement shall remain valid and in full force and effect from and after the date opposite the signature of the Participant until expressly revoked by the Participant in a written notice personally delivered to the Sponsor.

8. This Agreement shall be construed under Wyoming law in such manner as will render it, and each provision of it, fully enforceable; provided, however, that if any provision of this Agreement shall be unenforceable, such provision (or so much thereof as is unenforceable) shall be deleted and the remainder of this Agreement shall continue in full force and effect. Venue for purposes of any litigation or arbitration concerning this Agreement shall be in Sublette County, Wyoming.

9 I agree to and will follow all guidelines for personal hygiene, personal safety and public safety as recommended by MESA Therapeutic Horsemanship, Inc and my individual instructor. This may include, but is not limited to, waiting in my vehicle until I am asked to start the lesson either in person or via telephone; washing my hands prior to each lesson; use of hand sanitizer upon request; wiping down surfaces with disinfecting wipes and/or wearing a protective medical mask and/or gloves.

10. I agree to cancel my services should I have within the previous 24 hours to 2 weeks personally exhibited or have been in contact with someone who has presented with illness including; cough, sneezing, fever, chest congestion or additional signs of potential spread of any virus or bacteria/disease. In addition, I will follow the recommendations of my instructor once I have notified them of these risks in regards to my future services during this pandemic.

11. I am aware of the risks of contracting Covid-19 or other communicable diseases while receiving face to face services from MESA Therapeutic Horsemanship, Inc.

12. If this Agreement is executed by the undersigned for and on behalf of a minor Participant as named below, the undersigned hereby warrants and represents that he/she is in fact the legal parent or guardian of such minor, with full rights of custody and control; that this Agreement is given on behalf of and is intended to be binding upon said minor Participant, his/her heirs, personal representatives, successors and assigns; and the undersigned further agrees that this Agreement shall also be as fully binding on the undersigned as if it were entered into solely on his/her own behalf.

13. This Agreement shall be binding upon the heirs, personal representatives, successors and assigns of the Participant and the undersigned.

WARNING

Under Wyoming law, an equine activity sponsor or 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.

I HAVE FULLY READ AND FULLY UNDERSTAND THE FOREGOING EQUINE LIABILITY RELEASE, WAIVER OF RIGHT TO SUE AND ASSUMPTION OF ALL RISKS. I HAVE CONSULTED AND RELIED UPON MY OWN ADVISORS ON ALL QUESTIONS IN CONNECTION THEREWITH AND FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT. I HAVE NOT RELIED UPON THE SPONSOR FOR ANY ADVICE OR EXPLANATION IN CONNECTION THEREWITH.

Participant Name: _____Date: _____

Participant Signature: _____

Parent/Guardian Name: _____Date: _____

Parent/Guardian Signature: _____

Precautions and Contraindications for Equine Assisted Activities and Therapies

Please consider thoughtfully this brief list of conditions that may exclude individuals from participating in EAAT Activities provided by MESA. The severity of the Precautions will determine whether or not your child could participate safely. Contraindicaitons will prevent any person from participating in the MESA program. Please visit with the MESA director if you have any concerns.

Precautions	Contraindications
- Challenging behaviors - Fatigue levels - Medical equipment - Paralysis below T-6 - Spinal Curvature, fixation/fusion - Poor balance - Seizures - Medications - Sensory limitations - Allergies	- Lack of physician's release for EAAT - Children under 3 years old - - Weight over 200 lbs. - - Atlantoaxial Instability - Inability to communicate pain - Poor head control - Persistent primitive reflexes - Low skin integrity on weight bearing surfaces - Females with indwelling catheters - Complete spinal cord injury above T-6 - Insufficient spinal mobility to accommodate the movement of the equine - Larger individuals who are unable to sit unassisted on a flat surface with a back rest

Grounds for Dismissal from Program

Dismissal of a participant from MESA may occur due to any of the following reasons:

- The inability of the program to sufficiently meet the participant's needs physically or mentally
- The presence of contraindications, and possibly precautions if severe enough, for the chosen activity
- If a participant becomes a danger to themselves, our staff, or our horses
- If a participant displays uncontrolled negative behavior that has potential to be unsafe
- The participant displays the inability or unwillingness to follow directions related to safety

During the first infraction, possible alternatives are discussed with the participant or parent/guardian with the program manager to best suit the needs of the participant. *Subsequent infractions are grounds for dismissal.*

All terms listed above are for the benefit and safety for all the participants, staff, volunteers, and horses in the program. I have read the above and understand the terms in which I or my child may be dismissed from MESA programs.

Participant Name: _____

Signature: _____ Date: _____

Client or Parent/Legal Guardian

M.E.S.A. Therapeutic Horsemanship, Inc

MESA Equine Assisted Services

Physician's Statement Date: _____

Dear Health Care Provider:

Your patient, _____ , is interested in participating in programs with the M.E.S.A. Therapeutic Horsemanship (hereafter referred to as MESA). In order to safely provide this service, MESA requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to participation in some programs. Therefore, when completing this form, please note whether these conditions are present, and to what degree. Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in the selected program, please feel free to contact MESA at the address/phone indicated below.

Orthopedic

Atlantoaxial Instability – include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/ Myositis Ossificans
Joint sublaxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion
Spinal Joint Instability/ Abnormalities

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thoughts Control Disorders
Weight Control Disorder

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Cord/ Hydromyelia

Other

Age – under 5 years
Indwelling Catheters/Medical Equipment
Medications – i.e. Photosensitivity
Poor Endurance
Skin Breakdown

Physician's Notes & Comments: _____

_____

_____

Physician's Signature: _____ Date: _____

9888 US Hwy 191 | P.O. Box 516 | Pinedale, WY 82941 | 307.749.3979 | subletterides@gmail.com

MESA Therapeutic Horsemanship, Inc.
MESA Equine Assisted Services

Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight*: _____

Participant Address: _____ Phone: _____

Diagnosis: _____ Date of Onset: _____

Special Precautions /Needs: _____

This section MUST be complete. ***MESA horses are unable to carry riders over 200 lbs.**

Past/Prospective Surgeries: _____

Medications: _____

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

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs: _____

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 Atlanto Axial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Degree of Impairment or Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that MESA will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to MESA for ongoing evaluation to determine eligibility for participation.

Physician's Name & Title: _____ MD DO NP PA Other _____

Signature: _____ **Date:** _____

Address: _____

Phone: (_____) _____ License/UPIN Number: _____

Authorization for Emergency Medical Treatment

Participant's Name: _____DOB: _____

Address: _____City/State/Zip: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

In the event of emergency, please contact:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Consent Plan In the event emergency medical aid/treatment is required due to illness or injury during the process of participating in MESA programs, or while being on the property of MESA, I authorize the MESA staff to:

1. Secure and retain medical treatment and transportation if needed.
2. Release participant records upon request to the authorized individual or agency involved in the medical treatment.

This authorization includes x-ray, surgery, hospitalization, medication and any procedure deemed "life-saving" by the physician. This provision will only be invoked if the person(s) listed above is unable to be reached.

Date: _____ Consent Signature: _____
Client (if 18 years or older), Parent or Legal Guardian

Non-Consent Plan I do not give my permission for emergency medical treatment/aid in the case of illness or injury during the process of participating in MESA or while being on the property of MESA.
In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

Date: _____ Non-Consent Signature: _____
Client (if 18 years or older), Parent or Legal Guardian

Media/ Photo Consent

_____ I do
_____ I do not

authorize and give my full consent to MESA. to copyright and/or publish any and all photographs, quotes & statements, videotapes and/or film in which I or my child appears in while attending any MESA. event. I further agree that MESA may transfer, use or cause to be used, these photographs, videotapes, or films for any exhibitions, publications, public displays, commercials, art and advertising purposes, and television programs without limitations or reservations. I acknowledge, understand, and support MESA.'s plans to compile and publish a book, calendar, video or similar materials for MESA to use as advertising and fundraising containing volunteer and rider photographs/videos and quotes each year. These products will be also be used to thank donors for their support throughout the year.

Participant Name: _____ Signature: _____
Date: _____

Participant or Parent/Legal Guardian if under Age 18.

MESA Registration & Program Fees

Program Fees:
_____ $20/lesson - I will pay weekly during lessons

_____ $120/session - wlll pay in full for session(s).

_____ I will make payments for session(s). Please contact MESA to make arrangements.

_____ I have secured funding through fundraising efforts.

Amount raised: _____ Donors:_____

_____ I have secured BOCES funding in the amount of _____

_____ My child is on an IEP, 504, or other school funded program for MESA.

_____I would like to apply for scholarship funding to help support my child's lessons fees.

Name:_____ Signature: _____ Date:_____

Participant or Parent/Legal Guardian if under age 18.

Permission to Obtain & Release Information

Dear Parent:

In order to obtain and release information regarding your child, _____, please complete and return this form. If you have any questions, my contact information is provided below.

Name & Title of Contact Person	Address
Phone	**Email**

I, the undersigned, hereby request and authorize:	
School District or Public Agency:	**SCSD#**
Address:	
School District or Public Agency Contact Person:	**SCSD #**

To release to or obtain from:	
Agency:	MESA
Address:	PO Box 516, Pinedale WY 82941
Agency Contact Person:	Carla Seely

Information Provided for:	
Name of Child:	**Date of Birth:**

Information Requested:
☐ Official child academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement assessment results)
☐ Medical and/or related health records, including:
☐ Special Education confidential file (Evaluation, Eligibility & IEPs)
☐ Participation, development or implementation of the IEP and exchange of applicable agency documents.
☐ Other (specify):

Purpose of Disclosure

*** This permission is valid for one year from the date signed. A copy of this form is as effective as the original.**

I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. I recognize that health records, once received by the school district or public agency, may not be protected by the HIPPA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA). I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

Signature	Relationship	Date