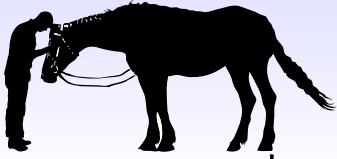


HORSES THAT HEAL HEARTS THAT CARE



THE RIGHT PATH  
HOOVES ON THE GROUND

THERAPEUTIC EQUINE-ASSISTED PROGRAMS

*at Quail Valley Ranch*

16620 Old Shamrock Highway Drumright, OK 74030

Dear Participant,

We invite you to experience the joys of equine-assisted activities and therapies in our **Hooves on the Ground** program at the **Right Path Riding Academy**.

The **Right Path Riding Academy, Inc.** is a 501(c) (3) non-profit organization dedicated to providing equine-assisted activities for individuals with a variety of special needs or challenges. We bring together a team of skilled horses, instructors certified by PATH International (Professional Association of Therapeutic Horsemanship, International) and a group of dedicated, fully-trained local volunteers to teach you the foundations of recreational riding and driving, horsemanship, and equine behavior. Our center is located at the Quail Valley Ranch in Drumright, OK.

Participation in the **Hooves on the Ground** program will give you an opportunity to learn a variety of equestrian skills which can improve balance, core muscle strength, self-confidence, focus, and countless other benefits. We also offer a full lunch at the end of each class to our participants and onsite volunteers.

If you would like to enroll in a session, please complete the following:

- Participant Application and Health History
- Liability Release
- Consent/Non-Consent for Media Release
- Participation Restrictions
- Confidentiality Statement

We are looking forward to having you in our program. Please feel free to contact us if you should have any questions.

Sincerely,

The Hooves on the Ground Team

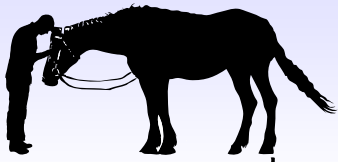
Our mission statement:

The Right Path's mission is to provide an equine-assisted environment to help people who have special needs, are disadvantaged, or at-risk to achieve their highest potential through our 4 programs: \*William's Walk Therapeutic Riding/Driving Program, \*Horse Tales Literacy Project, \*Trail Blazers Youth Enhancement Program, \*Hooves on the Ground Veterans Program.

(918) 352-4110

[walkon@rightpathridingacademy.org](mailto:walkon@rightpathridingacademy.org)

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HOOVES ON THE GROUND

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## *Hooves on the Ground*

### Participant's Application & Health History

#### 1. GENERAL INFORMATION

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

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

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

Ph. # Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

\* most reachable!!!

Most used email: \_\_\_\_\_

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

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

**Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_**

#### 2. HEALTH HISTORY

Diagnosis: \_\_\_\_\_

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

Medications: (include prescription, over-the-counter; name, dose and frequency)

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

Allergies:

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

Do you have any concerns about riding or being around horses?

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

Do you have any other concerns about participating in this program?

---

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### 3. PERSONAL ASSESSMENT

*Please consider each area and circle all words that you feel apply to you and your situation. It is okay to skip any question you feel uncomfortable answering.*

*This assessment is based on a resiliency model designed by the US. Army which integrates the Body, Mind, Spirit, and Family to promote a sense of becoming, changing, improving, and growing. Your answers will assist us in creating a meaningful therapeutic experience and all information is completely confidential!*

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#### **PHYSICAL**

Mobility: Ambulation / Independent / Level Surfaces Only / Need Supervision / Semi-dependent / Dependent / Assistive Devices / Gross Motor / Fine Motor / Motor Planning / Balance

Communication: Verbal / Words / Phrases / Sentences / Articulation / Signs / Gestures / Word recall / Receptive Language / Expressive Language / Difficulty Talking to Others

Vision: Visual Impairment / Assistive Devices/ Light Sensitivity / Night Vision / Visual Hypersensitivity

Auditory: Hearing Impairment / Assistive Devices / Auditory Defensiveness

Memory: Long Term / Short Term

Current Exercise/Therapeutic Regiment: PT /OT / Weights / Aerobic Exercise / Swimming / Yoga / Walking / Sports

Activities of Daily Living: Difficulties Bathing / Driving / Shopping / Work/ Recreational

General Fitness Level? \_\_\_\_\_

#### **EMOTIONAL/BEHAVIORAL**

Emotional: Depression / Anxiety / PTSD / Trauma / Mood Disorder / Abuse- Physical, Emotional, Sexual / Fearful / Angry

Behavioral: Impulse Control / Hyperactivity / Attention-Focus / Easily Frustrated / Avoidance / Substance Abuse

Current Therapies/Interventions: Currently in therapy? Y / N  
Completed a course of therapy? Y / N

Alcohol Use? Y / N

Smoker / Non-smoker?

Recreational Drug Use? Y / N

What do you do to calm down or to motivate yourself to relax, etc.

---

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**HOME & FAMILY**

Married: Y / N      Spouse: \_\_\_\_\_

Years Married: \_\_\_\_\_      Divorced? Y / N

Number of Children: \_\_\_\_\_      Ages: \_\_\_\_\_

Hometown: \_\_\_\_\_

What is Your Current Relationship with Family?

Maintaining Intimate Relationships / Positive Level of Understanding / Sharing of Thoughts and Feelings / Ease of Communication

Current Relationships with Friends: How much time do you spend in the company of others? \_\_\_\_\_

Prefer Individual or Group Activities?

Recreational Interest: What do you do for fun?

---

**SPIRITUAL**

How connected do you feel to the world around you?

Feelings of Isolation / Difficulty staying in the present / Unable to find meaning in life / Unable to see or appreciate beauty / Unable to create positive plans for the future / Unable to feel grounded within myself.

Do you have a spiritual community? \_\_\_\_\_

**PERSONAL GOALS**

What would you like to improve in your life in the next few months? \_\_\_\_\_

\_\_\_\_\_

What do you want to do that you can't do now? \_\_\_\_\_

\_\_\_\_\_

What would you like to learn or do around the horses in the next few months?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

**4. LIABILITY RELEASE**

\_\_\_\_\_ (Client's Name) would like to participate in the Right Path Riding Academy program. I acknowledge the risks and potential for risks of participating in the equine assisted activities that will be provided; however, I feel that the possible benefits for myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against The Right Path Riding Academy, its Board of Directors, INSTRUCTORS, therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in classes at the Right Path Riding Academy.

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

Client, Parent or Legal Guardian

## 5. PHOTO RELEASE

I \_\_\_ DO or \_\_\_ DO NOT consent to and authorize the use and reproduction by The Right Path Riding Academy & PATH Int'l 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

## 6. CONFIDENTIALITY STATEMENT

### **A. General Principles**

The Right Path Riding Academy shall preserve the right of confidentiality for all individuals in its program. To ensure this, we have created a Privacy and Confidentiality Policy.

### **B. Information Covered**

In fulfilling its mission, the Right Path Riding Academy collects and records information from students, parents, volunteers, foundations, and third parties. We recognize that it is our fiduciary duty to do what it takes to ensure that the information entrusted to us is available only to those with a need to know. Our confidential information is never released without the expressed written consent of the information owner. We take any violation of our privacy policy seriously, and the Right Path Riding Academy reserves the right to sever any relationship with an entity that violates this policy.

It is our policy to collect only the information necessary to fulfill our mission. The information that we collect in the process of our mission will not be given away or sold to third parties for marketing purposes. We do not disclose nonpublic personal information about staff, volunteers, business partners, or students except as required by law. We adhere to industry standard best practices for protecting our data, and those involved with the Right Path Riding Academy have been instructed on our privacy policy and their responsibilities in adhering to it.

### **C. Persons Subject to This Policy**

Anyone who works or volunteers for, or provides services to our riding academy is bound by this policy. This includes but is not limited to staff members, independent contractors, temporary employees, volunteers, and board members. It also applies to anyone connected with the center who could contain this information either accidentally or on purpose.

Signing below demonstrates that I have been informed and agree to the confidentiality requirements for participation in this program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Client, Parent or Legal Guardian

## 7. ACKNOWLEDGEMENT OF GENERAL RULES

### a. Clothing Restrictions:

- Straight leg or slightly flared (boot cut) long pants such as blue jeans or snug fitting leggings or riding breeches with knee-high socks to protect the lower leg if pants should ride up during a lesson. **Shorts are never permitted while riding.** In summer, jeans or cotton tights with t-shirts are appropriate.
- Boots or leather shoes with firm soles and HEELS, if possible should be worn. If the rider must use athletic shoes (running shoes) because of braces, etc, we can make an exception. However, **no riders wearing flimsy cotton tennis shoes or open-toed shoes or sandals will be permitted to ride or be in proximity to the stable area, arena or horses.**
- **NO LOOSE, FLOPPY, oversize clothing** that could cause a safety hazard.
- **Equestrian helmets are required for all mounted/driving activities.** We do provide helmets for your use. If you wish to purchase one for yourself please consult with us as we are required to restrict helmet use to ASTM-SEI approved standards.

b. **Weapon Restrictions:** Absolutely no weapons of any kind (i.e., guns, knives, etc.) will be permitted on your person or in the common areas. Any weapon brought to the center **MUST** remain locked in your vehicle at all times.

c. **Drugs/Alcohol Restrictions:** No drugs or alcohol will be allowed on your person or on the premises. Likewise, persons who are under the influence of drugs/alcohol may be escorted off the premises.

d. **No Smoking:** If you want to smoke please do so in your vehicle.

e. **Observe and obey** all posted safety and restricted area signs.

f. **Abuse & Mistreatment:** The mistreatment, abuse, or verbal suggestions of abuse, of any person or animal will not be tolerated. Such treatment will result in removal from the program.

g. **Do Not Feed The Horses:** Instructors or staff will accept all treats for the horses.

h. **Cell Phones:** Cell phones are not permitted to be used or checked while in the arena. Please ensure phones are left in the car or are turned off.

i. **NO PETS ALLOWED** on the property other than official service dogs.

j. Family and guests are requested to sit quietly in the staging area or classroom.

k. Please remember to keep our facility clean by disposing of trash properly.

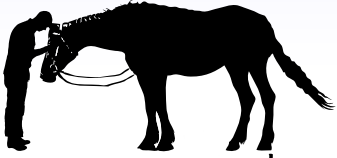
l. Parents/Caregivers are responsible for their children at all times.

Signing below demonstrates that I have been informed and agree to the required restrictions for participation in this program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Client, Parent or Legal Guardian

THERAPEUTIC EQUINE-ASSISTED PROGRAMS  
*at Quail Valley Ranch*  
16620 Old Shamrock Highway Drumright, OK 74030

HORSES THAT HEAL HEARTS THAT CARE



THE RIGHT PATH  
HOOFES ON THE GROUND

Date: \_\_\_\_\_

Dear Health Care Provider:

Your patient, \_\_\_\_\_  
*(participant's name)*

is interested in participating in supervised equine activities. In order to safely provide this service, our center 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 equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

**Orthopedic**

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

**Neurologic**

- Hydrocephalus/Shunt
- Seizure
- Spina Bilida/Chiari II Malformation/Tethered Coed/Hydromelia

**Other**

- Age- under 4 years
- Indwelling Catheters/Medical Equipment
- Medications – i.e. Photosensitivity

**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
- Migranes
- PVD
- Respiratory Compromise
- Recent Surgeries
- Substance Abuse
- Weight Control Disorder



Poor Endurance  
Skin Breakdown

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,

Joshalyn Ocker  
Operations Director

## Participant's Medical History & Physician's Statement

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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: I have examined this participant for Neurologic Symptoms of Atlanto Axial Instability:**

**(please initial) \_\_\_\_\_ Present \_\_\_\_\_ Absent**

*Please indicate current or past special needs 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			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that the NARHA center will weigh the medical information given

against the existing precautions and contraindications. Therefore, I refer this person to the NARHA center for ongoing evaluation to determine eligibility for participation.

Name/Title: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_

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

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

Phone: (\_\_\_\_) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_