



*Queen of Hearts Therapeutic Riding Center, Inc.*  
*Equine Services for Heroes*

*6405 Dana Avenue*  
*Jurupa Valley, CA 91752*  
*951-734-6300*



Thank you for your interest in Queen of Hearts Therapeutic Equine Services for Heroes. Our program offers ten equine therapy sessions free of charge to America's heroes. We work with past and present first responders and military service personnel. Programs offered have helped our heroes who need to deal with physical and emotional injuries. Professional counselors and equine specialists teach the injured how to work with concerns or issues in their lives through the power of horses.

To insure consistency of our volunteers, we need consistencies in our participants. Therefore, we ask that if you cannot commit to a minimum of 10 sessions, we ask you to let us know so we can open the session to others who are waiting their turn to participate. After two unexcused missed sessions, you will be dismissed from the program. Rules tend to have exceptions so please let us know if you need special arrangements.

The Wounded Warrior Project will sponsor ten sessions for Wounded Warrior Alumni. Community partners have sponsored participants for those who do not qualify as Wounded Warrior Alumni. If you want to continue after ten sessions, we offer services at a greatly reduced discount. Please let your instructor, counselor, or therapist know if you want to extend your sessions.

To register for Equine Services for Heroes, please complete and return this application to: Queen of Hearts Ranch, 6405 Dana Avenue, Jurupa Valley, CA 91752. After it is received, we will contact you to arrange a time for your first session. If you already have an appointment for your first session, please bring the completed packet with you.

Jurupa Valley is the town formerly known as *Mira Loma*. Queen of Hearts is located east of the 15 freeway between the 60 freeway and the 91 freeway. To get here:

- ♥ I-15 to Limonite - then go East to Wineville (the second signal from the freeway)
- ♥ Turn South (right) on Wineville and go to the first street on the left - 64th Street
- ♥ Turn East (left) on 64th Street.
- ♥ You will pass a STOP sign at Smith Street. As you approach the next street (DANA) you will see a white wooden fence along the right side of the street. This is our arena.
- ♥ If you don't have physical challenges, please park across the street from the arena but not immediately next to the arena fence. Otherwise, proceed to Dana and turn South (right) on to Dana and park there. Please leave the handicapped parking area for our clients who have physical challenges.

*We all look forward to meeting you and working with you to accomplish our mutual goals.*

## **Equine-Assisted Activities and Therapies (EAAT)**

### **Definitions and Description of Services**

At Queen of Hearts Therapeutic Riding Center, Inc., some participants ride in our program and some don't. Those that want to ride will need to have signed permission from their physician. (The form is included in this packet.) Every effort will be made to avoid any accident; however, NO LIABILITY can be accepted by any of the organization's trustees, agents, employees, each and every one of its members and associates, the property owners upon whose land the lessons are conducted.

### **Explanation of Services:**

**THERAPEUTIC** is of or relating to the promotion of health. In all equine facilitated mental health and learning, whether activity or therapy based, the work with horses and humans is therapeutic. What that means is that our comments to the clients and people coming into our barns should be therapeutic in nature. This means that our staff has the clients' and equines' needs in the forefront and not our own.

**THERAPY** is an instrument used to relieve or heal a disorder. Only a licensed professional can conduct therapy. That might be an occupational therapist, physical therapist, or a speech therapist. These individuals must be certified to conduct therapy and often have to update their training by attending additional trainings each year. Hippotherapy is an example where a licensed therapist uses the horse as a medical modality as they conduct therapy in their specialized field.

**PSYCHOTHERAPY** is the treatment of mental disorders by psychological rather than medical means. Professionals calling themselves psychotherapists must have specific training that enables them to become licensed in their fields. Every state requires different credentialing for their mental health license. Practicing as psychotherapists demands that therapists continue to learn and grow as clinicians working in their field. Only licensed mental health professionals can conduct psychotherapy.

**EQUINE-ASSISTED ACTIVITIES** encompass many different activities involving the equine as a partner in the learning process. It can include Equine-Facilitated Learning (**EFL**) or Equine-Facilitated Psychotherapy (**EFP**). EFP/EFL therapeutic riding sessions are different from traditional riding sessions because they are therapeutic in nature and require the applicable credentialed facilitators.

**EQUINE-FACILITATED PSYCHOTHERAPY (EFP)** promotes personal exploration of feelings and behaviors and allows the clinical interpretation of such. This requires the presence of appropriately licensed and credentialed mental health professionals (**MHP**) who are currently practicing psychotherapy. In EFP, the session will have clearly defined goals and objectives set by the MHP in the individual's treatment plan. The sessions may be mounted and designed and taught by a TRI and a PATH Intl Certified Equine Specialist in Mental Health and Learning (**ESMHL**), or unmounted taught by the ESMHL.

**EQUINE-FACILITATED LEARNING (EFL)** promotes personal exploration of feelings and behaviors in an educational format. It may be designed and taught by a PATH Intl. Instructor and an Educator or Counselor. The sessions may be mounted or unmounted. The sessions may or may not include horsemanship. A PATH Intl. Certified Therapeutic Riding Instructor (**TRI**) must be present for all mounted sessions and the TRI must be directly supervising the activity. EFL activities support the specific goal for the individual clients, even if the clients participate in group sessions. The planning is usually conducted with input from the clients' therapists, educators, or counselors but the therapists, educators, or counselors may or may not be present.

<b>Hippotherapy</b>	<b>Mounted Activities Include TR &amp; EFL</b>	<b>Unmounted Activities EFL</b>	<b>Psychotherapy EFP</b>
Conducted by an OT/PT/ST	Conducted by TRI	Conducted by ESMHL	Conducted by MHP & ES
Includes TRI	If EFL, MHP may be present	Counselor/Educator may be present	May be mounted or unmounted
	If EFP, MHP must be present	Sessions may include horsemanship	EAGALA sessions are not mounted and do not include horsemanship

Office Use Only  
 Riding: \_\_\_\_\_  
 WWP: \_\_\_\_\_  
 Excel: \_\_\_\_\_  
 EFL/EFP: \_\_\_\_\_

**Queen of Hearts Therapeutic Riding Center, Inc.**  
 6405 Dana Avenue, Jurupa Valley, California 91752 - (951) 734-6300

**VETERAN REGISTRATION**



PLEASE FILL OUT ALL PAGES OF THIS APPLICATION AND **RETURN TOGETHER** AS A WHOLE PACKET



**GENERAL INFORMATION:**

NAME OF PARTICIPANT: \_\_\_\_\_  
 DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
 REFERRED BY: \_\_\_\_\_

SPOUSE/CARETAKER CONTACT (if applicable) \_\_\_\_\_  
 PRIMARY PHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

**HEALTH INFORMATION:**

PHYSICIAN NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 OFFICE PHONE: \_\_\_\_\_  
 MEDICAL DIAGNOSIS: \_\_\_\_\_ DATE OF ONSET: \_\_\_\_\_

Please indicate current or past problems in the following areas:

	Y	N	COMMENTS
ALLERGIES			
BACK INJURIES/SCOLIOSIS			
BEHAVIORAL			
BONE/JOINT			
BREATHING			
CIRCULATION			
COMMUNICATION			
DIGESTION			
ELIMINATION			
EMOTIONAL			
HEARING			
HEART			
MUSCULAR			
PAIN			
SENSATION			
THINKING/COGNITION			
VISION			

CURRENT MEDICATIONS (including over-the-counter): \_\_\_\_\_  
 \_\_\_\_\_

PRECAUTIONS/RESTRICTIONS (Please indicate all implants, shunts, appliances, devices, etc.): \_\_\_\_\_  
 \_\_\_\_\_

**DESCRIBE YOUR ABILITIES/DIFFICULTIES IN THE FOLLOWING AREAS (include assistance required or equipment needed):**  
 (i.e. mobility skills such as transfers, waling, wheelchair use, driving/bus riding): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**VETERAN REGISTRATION**

**Consent for Equine Assisted Activities and Therapy**

♥ I would like to participate in Queen of Hearts Equestrians Services for Heroes program. I have discussed this with my doctor. Furthermore, I grant permission to a Queen of Hearts' instructor or therapist to contact my doctor or therapist to further clarification of medical information if needed (this information will be treated with confidentiality).

♥ I understand that NO LIABILITY can be accepted by any of the organizations concerned with this instruction or therapy, including QUEEN OF HEARTS THERAPEUTIC RIDING CENTER, INC. and QUEEN OF HEARTS RANCH.

♥ I understand that the final decision regarding acceptance, selected therapeutic activities, and continued participation rests with the Queen of Hearts' staff, upon due consideration of the individual's special needs and the safety of the participant, staff, volunteers and horses.

♥ I am interested in the following services. (Please call (951) 734-6300 to speak to clarify any questions you may have regarding which services may be best for your individual situation.)

<b>Mounted:</b>		<b>Unmounted:</b>		<b>EAGALA</b>	
Therapeutic Riding		Horsemanship		Unmounted & No Horsemanship	
With Counselor		With Counselor		With Counselor	
With Psychotherapist		With Psychotherapist		With Psychotherapist	

**Participant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Participant's Printed Name:** \_\_\_\_\_

## **CONFIDENTIALITY POLICY and PHOTO RELEASE**

### **I. General Principles**

Riders and their families have a right to privacy that gives them control over the dissemination of their medical or other sensitive information. Queen of Hearts Therapeutic Riding Center, Inc. shall preserve the right of confidentiality of all individuals in its program.

### **II. Information Covered by the Confidentiality Policy**

You must maintain the confidentiality of personal information regardless of how it is obtained. Disclosures can occur because a chart, record or computer screen is left unattended. Someone may overhear a discussion or a third party may give information. This kind of information is protected and persons who receive this information must not disclose it to anyone else without proper authorization. Therefore, staff and volunteers shall keep confidential all medical, social, referral, personal and financial information regarding a person and his/her family.

### **III. Persons Subject to the Confidentiality Policy**

Anyone who works or volunteers for, or provides services to, the therapeutic riding center is bound by the policy. This includes, but is not limited to: Full- and part-time staff, independent contractors, temporary staff, volunteers, board members, and clients.

### **IV. Competency and Informed Consent Disclosure**

A rider may not be competent to give consent for disclosure of medical or sensitive information or both (including photographs and videotapes) because of age or mental incapacity. As a general rule, infants and children under age 18 do not have legal authority to consent to disclosure. Only parent(s), legal representatives or others defined by state statute generally have this authority. Adults with developmental disabilities are presumed legally competent to give or deny consent to disclosure unless they have been adjudicated incompetent to make this type of health care decision. If a substitute decision maker has been appointed, you must obtain specific information written consent from that individual.

### **V. Intra-Agency Access to and Disclosure of Medical and/or Sensitive Information**

The number of staff members requiring medical or sensitive information or both at a health care facility is likely to be higher than at a therapeutic riding center. Queen of Hearts Therapeutic Riding Center, Inc.'s policy is to not permit access to, nor disclosure of, such information without riders consent based on a perceived need to protect staff or anyone else possible exposure through casual contact.

Casual contact poses no risk of transmission of diseases such as HIV. The most effective method of protection for situations in which staff may be exposed to the blood of a rider is the use of infection control procedures. These procedures will be used with all riders under the assumption that all riders may have HIV, hepatitis or other blood borne diseases. Knowledge that a particular rider has a HIV infection does not protect staff members from transmissions; using universal precautions does.

### **VI. Extra-Agency Disclosure of Medical and/or Sensitive Information**

Queen of Hearts Therapeutic Riding Center, Inc. will not disclose information to outside agencies or individuals without the specific written consent of the rider.

### **VII. Penalties for Unauthorized Disclosures**

Personal and professional penalties can result from breaching confidentiality such as reprimand, loss of certain job responsibilities and termination.

**I HAVE RECEIVED, READ, UNDERSTAND AND OBSERVE THE QUEEN OF HEARTS THERAPEUTIC RIDING CENTER, INC.'S CONFIDENTIALITY POLICY.**

**Participant's Name/Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**RELEASE AND HOLD HARMLESS**

**WARNING**

**Under the Equine Activity Liability Act, each participant who engages in an equine activity expressly assumes the risks of engaging in and legal responsibility for injury, loss, or damage to person or property resulting from the risk of equine activities.**

The programs at QUEEN OF HEARTS RANCH ("QUEEN OF HEARTS") provide therapeutic horseback riding for able-bodied and disabled children and adults. Volunteers and horses are carefully selected and trained and safety equipment is required for all riders since horseback riding is a risk exercise. No student will be accepted for riding instruction and no volunteer accepted for service until this form has been READ, UNDERSTOOD, COMPLETED and SIGNED by the parent(s) or guardian(s) of a minor, or if the student or volunteer is of legal age and sound mind, by the student or volunteer.

Although participation in the program is under strict supervision and every effort is made to avoid injury or accident, the undersigned acknowledges the inherent risks involved in riding and working around horses. This includes bodily injury from horseback riding or being in close proximity to horses. Among other risks, both horse and rider can be injured in normal use or in competition and schooling. In order to provide this valuable service, NO LIABILITY will be accepted by QUEEN OF HEARTS, or any of the organizations, officers, directors, instructors, personnel, volunteers or other persons connected with the above named facility.

IN CONSIDERATION for the privilege of riding and/or working around horses at QUEEN OF HEARTS, the undersigned, as self, or as parent(s) or guardian(s) of the undersigned minor, jointly and severally, do hereby agree to release, hold harmless and indemnify QUEEN OF HEARTS, its officers, directors, trustees, agents, employees, representatives, successors and assigns, from all manner of liability, loss, costs, claims, demands and damages of every kind and nature whatsoever, including but not limited to reasonable attorney fees, which the undersigned or said minor may now or in the future have against QUEEN OF HEARTS, its officers, directors, trustees, agents, employees, representatives, successors and assigns, on account of any accident, damage, injury or illness, physical or mental condition, known or unknown, to the undersigned or said minor, or the treatment thereof, arising as a result of, or in any way connected to acts or incidents occurring at or relating to QUEEN OF HEARTS, its officers, directors, trustees, agents, employees, representatives, successors or assigns, including but not limited to their negligence or gross negligence in rendering the services described above or in anyway incidental thereto.

**Participant's Name/Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

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

Parents or Legal Guardians: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

PHONE NUMBERS: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT:**

\_\_\_\_\_  
Name Address PHONE: \_\_\_\_\_

PRIMARY PHYSICIAN'S NAME: \_\_\_\_\_

PREFERRED MEDICAL FACILITY: \_\_\_\_\_

HEALTH INSURANCE COMPANY: \_\_\_\_\_ POLICY#: \_\_\_\_\_

**HEALTH HISTORY** (Consult your physician or local health department if you are not up to date with these shots/tests.)

**Recent Medical Tests:** Last Tetanus Shot: \_\_\_\_\_ Tuberculosis Test + - Date: \_\_\_\_\_

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries, or lifestyle changes. List all pertinent medical information (allergies to food or drugs, medications being taken, special medical conditions): \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

**CONSENT PLAN:**

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 Queen of Hearts Ranch/Queen of Hearts Therapeutic Riding Center, 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.

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 listed is unable to be reached.

**Participant's Name/Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**NON-CONSENT PLAN:**

I specifically DO NOT give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services from Queen of Hearts Therapeutic Riding Center, Inc. or while being on the property of Queen of Hearts Ranch. In the event such emergency/treatment/aid is required, I wish the following procedures to take place.

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

**Participant's Name and Non-consent Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Queen of Hearts  
Therapeutic Riding Center, Inc.*

*A Non-Profit Therapeutic Horseback Riding Center for People with Disabilities\**

6405 Dana Avenue  
Jurupa Valley, CA 91752  
(951) 734-6300  
queenofheartsranch.com



PATH Int'l Premier Accredited  
Center No. 43710  
PATH Int'l Certified Instructors  
\* EIN No. 33-0907556

Dear Health Care Provider:

One of your clients/students is interested in supervised equestrian activities. Enclosed is an assessment form which will help our therapists and instructors to develop a safe and effective riding program for him/her. Please fill out the areas that pertain to your expertise, and/or attach any existing assessments or reports that you think will be helpful to our staff.

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.

Therapeutic riding is a unique and productive way to improve the quality of life for many children and adults with physical, cognitive or psychological disabilities. Queen of Hearts Therapeutic Riding Center, Inc. serves many such people each week from within the Inland Empire and beyond. Your participation in our program is invited. Please feel free to call or visit if you would like more information.

**CONDITIONS THAT MAY SUGGEST PRECAUTIONS AND CONTRAINDICATIONS**

**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 Bifida/Chiari II Malformation/Tethered  
Cord/Hydromyelia

**Other**

Age – under 4 years  
Indwelling Catheters/Medical Equipment  
Medications – i.e., Photosensitivity  
Poor Endurance  
Skin Breakdown

**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  
Thought Control Disorders  
Weight Control Disorders

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.





**PHOTO RELEASE**

I         DO  
           DO NOT

consent to and authorize the use and reproduction by QUEEN OF HEARTS RANCH, and/or QUEEN OF HEARTS THERAPEUTIC RIDING CENTER, INC. (collectively "QUEEN OF HEARTS") of any and all still and/or moving photographs and films, including television pictures, of

\_\_\_\_\_  
(Enter Participant's Name)

and consent and authorize QUEEN OF HEARTS to use and reproduce the photographs, films and pictures and to circulate and publicize the same by all means including, but not limited to, newspapers, television media, brochures, pamphlets, instructional materials, books and clinical material.

With respect to the foregoing matters, no inducements or promises have been made to me/us to secure my/our signature(s) to this release other than the intention of QUEEN OF HEARTS and its work.

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent #1/Guardian #1 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_

Parent #2/Guardian #2 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_

**RIDER'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT**

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

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date Of Onset: \_\_\_\_\_

**For those with Down Syndrome:** Cervical X-Ray for Atlanto-Axial Instability:

Positive \_\_\_\_\_ Negative \_\_\_\_\_ X-Ray Date \_\_\_\_\_

Tetanus shot: No \_\_\_ Yes \_\_\_ Date: \_\_\_\_\_

Seizures: Type \_\_\_\_\_ Controlled?: No \_\_\_ Yes \_\_\_ Date of Last Seizure: \_\_\_\_\_

Medications: \_\_\_\_\_

**HEALTH HISTORY:** Please indicate current or past problems in the following areas, including surgeries:

	NORMAL	PROBLEMS/DEFICITS	COMMENTS/SURGERIES
ALLERGIES			
AUDITORY			
BACK INJURIES/SCOLIOSIS type/degree			
BALANCE			
BEHAVIORAL			
CARDIAC			
CIRCULATORY			
COGNITIVE			
EMOTIONAL/PSYCHOLOGICAL			
IMMUNITY			
LEARNING DISABILITY			
MUSCULAR			
NEUROLOGICAL			
ORTHOPEDIC			
PULMONARY			
RESPIRATORY			
TACTILE SENSATION			
VISION			
SHUNT	YES:	NO:	
GI TUBES	YES:	NO:	
CATHETER	YES:	NO:	
OTHER			

**MOBILITY:**

INDEPENDENT AMBULATION Y \_\_\_ N \_\_\_ BRACES Y \_\_\_ N \_\_\_ CRUTCHES Y \_\_\_ N \_\_\_ WHEELCHAIR Y \_\_\_ N \_\_\_

OTHER SPECIAL PRECAUTIONS/RESTRICTIONS: \_\_\_\_\_

**This Form MUST BE Signed By a Physician Before a Participant May Ride**

**I have reviewed the CONTRAINDICATIONS attached to this form.** In my opinion, this patient has none of these contraindications and may participate in supervised equestrian activities. In conjunction with these activities, I concur in the referral of the participant to a PT/OT/ or SLP or other health care professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program. I understand that the final decision regarding acceptance rests with the Queen of Hearts Therapeutic Riding Center, Inc. staff, upon due consideration of the participant's special needs, precautions and contraindications, and the safety of the participant, staff, volunteers and horses.

PHYSICIAN'S NAME (please print) \_\_\_\_\_ Date: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ LICENSE/UPIN NUMBER: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_