Milestones Inc.
Equestrian Achievement Program

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

Milestones Authorization for Emergency Medical Treatment Form

Please fill out all requested information.

Rider name:_____ DOB: _____
Address:_____ Phone:_____

In case of emergency, please contact:

Name/Relationship	Day Phone	Evening Phone	Other Phone/Pager

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 to make health care decisions with respect to the student named.

Date:_____ Signature: _____

Physician's name:_____Phone: _____

Preferred Medical Facility: _____

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

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

Date:_____ Signature: _____

Print Name: _____

I have read and understand the Milestones, Inc rider handbook and agree to follow all rules and requirements outlined for riders and their families.
Signature:_____ Date:_____

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

12372 Riggs Road, Independence, KY 41051
Phone 859.694.7669 (phone) 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 Participant's Medical History & Physician's Statement Form

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

Participant name:_____ DOB:_____ Height:_____

Address: _____

Past/Prospective Surgeries: _____

Medications: _____

Special Precautions/Needs: _____

_____

Mobility: Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N

Braces/Assistive Devices: _____

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			
Osteoporosis			
Orthopedic			
Allergies			
Cognitive			
Emotional/Psychological			
Pain			
Other			

In my opinion, this patient can participate in supervised equestrian activities. I understand that Milestones 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: _____