Freedom Farm
11500 Ferman Avenue SW
Waverly, MN 55390
952-955-2505
info@freedomfarmmn.org www.freedomfarmMN.org

# Adaptive Riding
# 2024 Participant Checklist

***Note: Please fill in all forms completely to ensure that participants are able to begin lessons on schedule.***

___ **1. Sign and take to your doctor the 'Participant's Consent for Release of Information', 'Health Care Provider Letter' and the Participant Medical History and Physician Statement'. They will need to mail it back before the date of the first lesson.**
(An envelope addressed to Freedom Farm can help speed the return mailing!)

___ **2. Read, sign and date the 'FREEDOM FARM 2024 POLICIES'.**
Please read it carefully!

___ **3. Complete, sign and date the 'Participant's Application and Health History'**

___ **4. Complete, sign and date the 'Authorization for Emergency Medical Treatment Form'**

___ **5. Read, sign and date the 'Release and Agreement'**

- Freedom Farm recommends each participant have their own helmet.
  ** Helmets must be approved ASTM/SEI Certified **

- Freedom Farm must coordinate volunteers, horse handlers and horses to provide each student with a safe and effective therapy session. We feel that scheduling is paramount to meeting not only our students' needs, but also those of our staff and volunteers. Participants *of all abilities achieve the greatest benefits from consistency in their lessons.* We ask that all our participants make a commitment to attend all scheduled lessons.

- Freedom Farm operates as a non-profit organization and has financial responsibilities to you and business suppliers. The policies were approved by the Freedom Farm Board of Directors. They are in place to ensure Freedom Farm's continued success.

Thank you for your continued commitment to Freedom Farm. Please call (952-955-2505) or email (info@freedomfarmmn.org) if you have further questions.

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# Freedom Farm 2024 Policies
## 2024 Lessons

**Payment Policy**
- $75 per lesson
- Special Billing – Please call to let us know what is needed.

**Helmets, boots/tennis shoes and long pants are required for all participants.**

**Absence & Cancellation Policy**
Please give 24 hour notice whenever possible. This is very important so we have enough time to inform volunteers.

Freedom Farm reserves the right to deny participation in any program activity that, in the professional opinion of the Freedom Farm staff, presents a risk to the safety and/or well being of the horses, staff, volunteers and/or other participants.

***PHOTO POLICY: PHOTOS*** taken at Freedom Farm of participants/volunteers other than YOUR child may not be posted to Facebook or other social media sites. Please respect the privacy of all participants & volunteers.

**I have read and understand the above policies.**

Signature _____ Date _____

*Please return to Freedom Farm. Thank you.*

**Photo Release**
I __ DO __ DO NOT consent to and authorize the use and reproduction by Freedom Farm 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 center (including website, Freedom Farm Facebook/Instagram & newspapers).

***Signature:*** _____ ***Date:*** _____
Client, Parent or Legal Guardian

**Confidentiality Agreement**
I understand that all information (written and verbal) about participants at this PATH center is confidential and will not be shared with anyone without the expressed written consent of the participant and their parent/guardian in the case of a minor.

***Signature:*** _____ ***Date:*** _____

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**SEND TO FREEDOM FARM**

# 2024 Participant's Application and Health History (Page 1 of 2)

Participant: _____

DOB: _____ Age: _____ Gender: M F **Height:** _____ **Weight:** _____ **T-shirt size** _____

Home Address: _____ City: _____, **MN** **Zip:** _____

**Home Phone:** _____ **Cell Phone:** _____

**E-mail:** _____
Please add info@freedomfarmmn.org to your safe list.

Parent work phone: _____

Parents/Legal Guardian (BOTH NAMES): _____

Address (if different): _____

Referral Source: _____ Phone: _____

How did you hear about the program? _____

**HEALTH HISTORY**
Diagnosis: _____ Date of Onset: _____

*Please indicate current or past special needs in the following areas:*

| | Yes | No | Comments |
|---|---|---|---|
| Vision | | | |
| Hearing | | | |
| Sensation | | | |
| Communication | | | |
| Heart | | | |
| Breathing | | | |
| Digestion | | | |
| Elimination | | | |
| Circulation | | | |
| Emotional/Mental Health | | | |
| Behavioral | | | |
| Pain | | | |
| Bone/Joint | | | |
| Muscular | | | |
| Thinking/Cognitive | | | |
| Allergies | | | EpiPen? Yes No |

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## 2024 Participant's Application and Health History (Page 2 of 2)

**MEDICATIONS** *(include prescription, over-the-counter; name, dose and frequency)*

_____

_____

_____

_____

_____

*Describe your abilities/difficulties in the following areas* ***(include assistance required or equipment needed)****:*

**PHYSICAL FUNCTION** (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

_____

_____

_____

**PSYCHO/SOCIAL FUNCTION** (i.e. Work/school including grade completed, leisure interests, relationships – family structure, support systems, companion animals, fears/concerns, etc)

_____

_____

_____

_____

**GOALS** (i.e. Why are you applying for participation? What would you like to accomplish?)

_____

_____

_____

_____

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# 2024 Authorization for Emergency Medical Treatment Form

Participant Name: _____ DOB: _____ Phone: _____

Address: _____City _____, MN, Zip _____

Physician's Name & Clinic: _____ Preferred Hospital: _____

Health Insurance Company: _____ Policy #: _____

List all Allergies (medication, food, etc.): _____

Current medications: _____

**In the event of an emergency, contact:**

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

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 **Freedom Farm** 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.

***PLEASE CHOOSE ONE***

☐ **Consent Plan**
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(s) above is unable to be reached.

☐ **Non-consent Plan**
I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency.

**In the event emergency treatment/aid is required, I wish the following procedures to take place:**

---

**Date:** _____ **Signature:** _____
Client, Parent or Legal Guardian

Office Use Only: □ GW □ Email □ Call List

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# 2024 Release and Agreement

1. I, _____, the undersigned or my minor child, (herein called Releasor), in consideration of being permitted to use the facilities and services of Bjorklund Training Stable/Freedom Farm for himself/herself, spouse, my minor child, legal representatives, heirs and assigns, HEREBY RELEASES, WAIVES AND DISCHARGES BJORKLUND TRAINING STABLE/FREEDOM FARM, (HEREIN CALLED RELEASEE) THE OWNERS AND LESSEES OF BJORKLUND TRAINING STABLE/FREEDOM FARM INCLUDING TOM BJORKLUND AND SUSAN BJORKLUND THEIR AGENTS, EMPLOYEES AND VOLUNTEERS, FROM ALL LIABILITY TO THE RELEASOR, THEIR SPOUSE, LEGAL REPRESENTATIVES,HEIRS AND ASSIGNS, FOR ANY AND ALL LOSS OR DAMAGE, AND ANY CLAIM OR DAMAGES RESULTING THEREFROM ON ACCOUNT OF INJURY TO RELEASOR'S PERSON, EVEN INJURY RESULTING IN DEATH OF THE RELEASOR, WHETHER CAUSED BY THE NEGLIGENCE OF RELEASOR OROTHERWISE WHILE THE RELEASOR IS RIDING, WORKING, OR FOR ANY PURPOSE USING THE FACILITIES, EQUIPMENT OR SERVICES OF BJORKLUND TRAINING STABLE/FREEDOM FARM.

2. I agree to indemnify Bjorklund Training Stable/Freedom Farm, Tom Bjorklund, Susan Bjorklund and each of them from any loss, damage or cost they may incur due to the participation or use of the facilities, equipment and services of Releasee due to the presence of myself or my minor child in or upon the property owned, located at or controlled by Bjorklund Training Stable/Freedom Farm whether caused by the negligence of the Releasees or otherwise.

3. I fully understand any involvement with horses involves some risk of harm or injury to myself, my minor child, my horses or my other property and that risk of damage or injury is a normal incident of involvement with horse-related activities and I hereby agree that risk is borne by me an/or my minor child and not by Bjorklund Training Stable/Freedom Farm, Tom Bjorklund or Susan Bjorklund, or their officers, members, agents, employees or volunteers.

THIS RELEASE CONTAINS THE ENTIRE AGREEMENT BETWEEN THE PARTIES HERETO AND THE TERMS OF THIS RELEASE ARE CONTRACTUAL AND NOT A MERE RECITAL.

I HAVE CAREFULLY READ THE FOREGOING RELEASE AND KNOW THE CONTENTS THEREOF AND SIGNED THIS RELEASE AS MY OWN FREE ACT.

Releasor (Parent/Guardian) _____

Minor Child _____ Date_____

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**SEND TO PHYSICIAN**

# 2024 Participant's Consent for Release of Information

I hereby authorize: _____
*(person or facility)*

to release information from the records of: _____ DOB: _____
*(participant's name)*

The information is to be released to **Freedom Farm, Susie Bjorklund** for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

Medical History

☐ Physical Therapy evaluation, assessment and program plan

☐ Occupational Therapy evaluation, assessment and program plan

☐ Speech Therapy evaluation, assessment and program plan

☐ Mental Health diagnosis and treatment plan

☐ Individual Habilitation Plan (I.H.P.)

☐ Classroom Individual Education Plan (I.E.P.)

☐ Psychosocial evaluation, assessment and program plan

☐ Cognitive-Behavioral Management Plan

**X Attached Participant's Medical History & Physician's Statement, signed & dated**

☐ Other: _____

This release is valid for one year and can be revoked, in writing, at my request.

Signature: _____ Date: _____

Print Name: _____

Relation to Participant: _____

Please send materials to: Freedom Farm
Attn: Susie Bjorklund
11500 Ferman Ave SW
Waverly, MN 55390

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**SEND TO PHYSICIAN**

Date: _____

Dear Health Care Provider,

Your patient, _____ is interested in participating in supervised equine activities.
*(participant's name)*

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
Coxa Arthrosis
Cranial Deficits
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 Disorder

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,
Susie Bjorklund,
Executive Director
Freedom Farm

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# 2024 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:* AtlantoDens Interval X-rays Date: _____ Result: + --

Neurologic Symptoms of AtlantoAxial Instability: _____

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

| | Yes | No | Comments |
|---|---|---|---|
| Auditory | | | |
| Visual | | | |
| Tactile Sensation | | | |
| Cardiac | | | |
| Circulatory | | | |
| Integumentary/Skin | | | |
| Immunity | | | |
| Pulmonary | | | |
| Neurolgic | | | |
| Muscular | | | |
| Balance | | | |
| Orthopedic | | | |
| Allergies | | | |
| Learning Disability | | | |
| Cognitive | | | |
| Emotional/Psychological | | | |
| Pain | | | |
| Other | | | |

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Name/Title: _____ MD DO NP PA Other _____

**Signature:** _____ **Date:** _____

Phone: _____ **License/UPIN Number**: _____