Freedom Farm Therapeutic Riding Center
11500 Ferman Avenue SW
Waverly, MN 55390
952-955-2505

SEND TO FREEDOMFARM

Freedom Farm 'Mount Up ~ Walk On'

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 #: _____

Allergies to medications: _____

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

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

SEND TO FREEDOM FARM

Freedom Farm 'Mount Up ~ Walk On' Program

2024 Participant Application and Health History

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Please add info@freedomfarmMN.org to your safe list.

Referral Source: _____

Branch of Service: _____ Years of Service: _____

_____ **Provide copy of DD214 to be kept on file at Freedom Farm.**

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 activites, exhibitions or for any other use for the benefit of the program (this includes the website).

Signature: _____ Date: _____

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Freedom Farm 'Mount Up ~ Walk On'

2024 Participant Application and Health History (Page 2 of 5)

HEALTH HISTORY

Participant: _____

Diagnosis: _____

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			
Thinking/ Cognitive			
Pain			
Bone/Joint			
Muscular			
Allergies			

Signature: _____ Date: _____

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2024 Participant Application and Health History (Page 3 of 5)

Participant: _____

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, leisure interests, relationships – family structure, support systems, companion animals, fears/concerns, etc.)

_____

_____

_____

_____

_____

Signature: _____ Date: _____

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2024 Participant Application and Health History (Page 4 of 5)

Participant: _____

Describe your goals in the following areas (include long-term and short-term):

WORKING WITH HORSES

_____
_____
_____
_____
_____

MENTAL HEALTH GOALS

_____
_____
_____
_____
_____

Signature: _____ **Date:** _____

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Freedom Farm 'Mount Up ~ Walk On'

2024 Freedom Farm 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: _____ Date: _____

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info@freedomfarmmn.org www.freedomfarmMN.org

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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info@freedomfarmmn.org www.freedomfarmMN.org

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**: _____