STAT, INC.

Healing with Horsepower Since 2007

Ligonier Therapeutic Center, LLC

24 Stom Road, Ligonier, PA 15658

PATH PARTICIPANT APPLICATION PACKET

PARTICIPANT'S CONSENT FOR RELEASE OF INFORMATION AND PHOTOS/MEDIA

I hereby authorize STAT Inc.® to release information from the records of:

Patient/Participant's name:_____

DOB: _____

Information is to be released to: **STAT, Inc. and/or Ligonier Therapeutic Center** only for the purpose of developing an equine activity program for the above named Patient/Participant.

The information to be released is indicated below.

This Release and Photo Waiver is valid in perpetuity and can only be revoked with written request.

Signature: _____

Date: _____

Print Name: _____

Relation to Participant: _____

Please place a check mark in the box below to authorize Photo Waiver

☐ Photography Release: I hereby authorize STAT Inc. and/or the Ligonier Therapeutic Center, to publish photographs and/or videos taken of myself and/or the minor child(ren) in my company, for the use in online and video-based marketing materials, and company publications. I hereby release and hold harmless STAT Inc./Ligonier Therapeutic Center from any reasonable expectation of privacy or confidentiality for myself and for the minor child(ren) listed below associated with the images specified above. Further, I attest that I am the parent or legal guardian of the child or children listed below and that I have full authority to consent and authorize the use of these photos/media. I further Acknowledge that participation is voluntary and that neither I nor the minor child(ren) will receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other company publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever. I hereby release STAT Inc./Ligonier Therapeutic Center from liability for any claims by me or any third party in connection with my participation or the participation of the minor children listed below, in perpetuity

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RIDER MEDICAL FORM

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.

- ☐ Atlantoaxial Instability - include neurologic symptoms
- ☐ Allergies
- ☐ Coxarthrosis
- ☐ Cranial Defects
- ☐ Cardiac Condition
- ☐ Joint subluxation/dislocation
- ☐ Blood Pressure Control
- ☐ Osteoporosis
- ☐ Joint Fusion/Fixation
- ☐ Hydrocephalus/Shunt
- ☐ Seizure
- ☐ Respiratory Compromise
- ☐ Spina Bifida
- ☐ Malformation/Tethered
- ☐ Coed/Hydromyelia
- ☐ Indwelling Catheters/Medical Equipment

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 me at the number provided.

Sincerely,
Catherine J. Markosky
Founder & CEO, STAT, Inc.
(724) 593-4742

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PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant/Patient: _____

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: Neurologic Symptoms of Atlantoaxial Instability: ___Present ___Absent

Please note any additional information that would assist us in determining your patient's suitability for participation in a therapeutic riding program: _____

_____

_____

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 PATH Intl. Center together with PATH accredited personnel, medical doctor, will weigh the medical information given against the existing precautions and contraindications.

Print Name/Title: _____ Circle one: MD DO NP PA

Signature: _____ Date: _____

Address: _____

Phone number: _____License/UPIN Number: _____

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PATH PARTICIPANT APPLICATION PACKET

RIDER EVALUATION FORM

Name: _____ Date: _____

Conducted by: _____

Diagnosis: _____

Ambulatory Status: _____

Adapted Equipment Required: _____

Mounting/Dismounting (method, number of volunteers) _____

_____

Assistance needed (indicate Y/N, number, and type)

Walk _____

Trot _____

Canter _____

Steering _____

List Participant/Patient Goals:

_____

_____

_____

_____

Additional Notes/Observations From Evaluation:

_____

_____

_____

_____