# BITS KIDS

## Back In The Saddle Warriors® (BITS)

***Equine Therapeutic Riding Program for Injured/Disabled Children of Wounded Warriors***

HEARTBEAT
serving wounded warriors®

## Intake Packet

**www.heartbeatforwarriors.org**


**(425)931-1047**

**Heartbeat Serving Wounded Warriors®**

**PO Box 610**

**Onalaska, WA 98570**



# BITS KIDS EQUINE THERAPEUTIC RIDING

## NEW PARTICIPANT PACKET CHECKLIST

- ♡ DD214 of Wounded Warrior or if Active Duty copy of Orders or Referral
- ♡ Child 3-13 years of age
- ♡ Child up to 130 lbs
- ♡ BITS KIDS Intake Packet filled out by the parent and child's Physician

HEARTBEAT
serving wounded warriors®

P.O. Box 610, Onalaska, Washington, 98570 425-931-1047 Federal ID #03-0547294
email: janice@heartbeatforwarriors.org

**www.heartbeatforwarriors.org**

# BITS KIDS


***Please Print*** Today's date: _____

Name of Child: _____ Birthdate: _____
First MI Last

Address: _____

Parent/Legal Guardian Name(s): _____

Parent's email: _____ Parent/Legal Guardian's home phone #: _____

Cell Phone #: _____

Emergency Contact Person: _____ Phone: _____

Any Known Allergies for child: _____

**Medical History (Parent to fill out)**

Injury/problem, disability of child: _____

Date/onset of injury/disability: _____ Surgery date (if any): _____

Referring doctor: _____ Primary/regular doctor: _____

Current Medications: _____

Diagnostic work done? If so what? (x-rays, MRl, CT scan, etc.): _____

Current Exercise Habits: _____

Goals for Child: _____

Aggravating factors (what makes symptoms worse): _____

Alleviating factors (what makes symptoms better): _____

Any medical diagnoses the child has: _____

# BITS KIDS


INFORMATION RELEASE FOR PARENT/LEGAL GUARDIAN TO SIGN:

I give permission for my child _____'s medical information to be given to any personal that are associated with the BITS KIDS Equine Therapeutic Riding program and Heartbeat Serving Wounded Warriors® administrators.

Signature of Parent/Legal Guardian: _____ Date_____

BITS KIDS, EQUINE THERAPEUTIC RIDING RELEASE OF LIABILITY AND INDEMNITY AGREEMENT:

I, the Parent/Legal Guardian _____ of (name of child) _____hereby acknowledge that we have voluntarily registered to participate in the Equine Therapeutic Riding program, BITS KIDS, a program of Heartbeat Serving Wounded Warriors® and Healing Hearts Ranch.

I, the Parent/Legal Guardian _____ of (name of child) _____ recognize there are risks being around horses in participation of Equine Therapeutic Riding with BITS KIDS. I hold harmless and completely release all liability (including but not limited to law suits) to Heartbeat Serving Wounded Warriors®, The Board of Heartbeat Serving Wounded Warriors®, BITS KIDS, Healing Hearts Ranch, PATH Instructor Kristy Dees, Chelsea Johnson, Health Care Specialist and Veteran liaison Tracy Lamie, all volunteers, and employees for any possibilities of injuries or death to my child, (name of child) _____ _____.

**This is a release of liability. Do not sign or Initial the release if you do not understand and/or agree with its terms.**

Participants under 18 years of age require the signature of a parent or legal guardian.

Signature of Parent or Legal Guardian: _____

Print name of Parent or Legal Guardian: _____

Date: _____

# BITS KIDS


**MEDICAL HISTORY TO BE FILLED OUT BY PHYSICIAN OF CHILD**

Date _____

Name: _____ DOB: _____ Age: _____

Address: _____ Phone: _____

Sex: _____ Height: _____ Weight: # _____
Diagnosis: _____

Cause: _____

Medications (Type, Purpose, Dose): _____

If Down Syndrome:
Cervical X-Ray for Atlanta-Axial Subluxation: Positive: ____ Negative: ____ X-Ray Date: _____

---

Please indicate if the client had or has a history of the following secondary problems by checking yes or no.

If YES, please include COMPLETE information pertaining to the problem.

| YES | NO | CONDITION |
|---|---|---|
| 0 | 0 | Spinal Fusion - if yes, which vertebrae: _____ |
| 0 | 0 | Spinal Instability/ Abnormalities - if yes, which vertebrae: _____ |
| 0 | 0 | Scoliosis - if yes, explain: _____ |
| 0 | 0 | Kyphosis (Excessive or Abnormal) |
| 0 | 0 | Lordosis (Excessive or Abnormal) |
| 0 | 0 | Hip Subluxation and/or Dislocation - if yes, describe: _____ |
| 0 | 0 | Osteoporosis |
| 0 | 0 | Pathologic Fractures |
| 0 | 0 | Arthritis – Type: _____ |
| 0 | 0 | Coxarthrosis |
| 0 | 0 | Heterotopic Ossification |
| 0 | 0 | Osteogenesis Imperfecta |
| 0 | 0 | Spinal Orthosis |
| 0 | 0 | Internal Spinal Stabilization Devices – Type: _____ |
| 0 | 0 | Hydrocephalus with Shunt - Location of Shunt: _____ |
| 0 | 0 | Spina Bifida - Type and Level: _____ |


# BITS KIDS

| YES | NO | CONDITION |
|---|---|---|
| 0 | 0 | Tethered Cord |
| 0 | 0 | Chiari Malformation |
| 0 | 0 | Hyclromyelia |
| 0 | 0 | Paralysis |
| 0 | 0 | Cranial Deficits |
| 0 | 0 | Cerebral Palsy-Type: _____ |
| 0 | 0 | Gastrostomy Tube-Type: _____ |
| 0 | 0 | Atlantoaxial Instabilities: _____ |
| 0 | 0 | Seizures –Type: _____ Date of last Grand Mal Seizure: _____ |
| 0 | 0 | Controlled with medication - if yes, list: _____ Last date adjusted: _____ |
| 0 | 0 | Allergies -Type: _____ |
| 0 | 0 | Diabetes -Type: _____ |
| 0 | 0 | Autism |
| 0 | 0 | Poor Endurance |
| 0 | 0 | Hemophilia |
| 0 | 0 | Hypertension |
| 0 | 0 | Controlled with medication - if yes, list: _____ |
| 0 | 0 | Heart Condition-Type: _____ |
| 0 | 0 | Cerebrovascular Accident (Stroke) – Date: _____ |
| 0 | 0 | Cancer –Type: _____ |
| 0 | 0 | Aneurysm |
| 0 | 0 | Known embolus- Location: _____ |
| 0 | 0 | Known thrombus – Location: _____ |
| 0 | 0 | Current Tetanus Shot- Date: _____ |

Known Behavior Problems: _____

_____

Incontinence: _____ Postural Muscle Tone: _____

Visual Defects: _____ Auditory Defects: _____

Speech Defects: _____ Neuro-Sensation: _____

Coordination Problems: _____ Spasticity and/or Rigidity: _____

Braces: _____ Assistive Devices (i.e. wheelchair, crutches, etc.): _____

# BITS KIDS


General Comments

_____

_____

_____

_____

_____

I see no reason why this child _____ cannot participate in the BITS KIDS Equine Therapeutic Riding Program.

Physician's Signature: _____ Date: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone: _____ Fax: _____

**MEDICAL FORMS MUST BE SIGNED AND DATED BY PHYSICIAN**