

BITS KIDS

Back In The Saddle Warriors® (BITS)

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



Intake Packet

www.heartbeatforwarriors.org

(425) 931-1047

Heartbeat Serving Wounded Warriors®

PO Box 704

Snohomish, WA 98291



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



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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, MRI, 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: _____



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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: _____



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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: _____



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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.): _____



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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

