Participant Registration

Participant Name: _____ Date: _____

Phone: _____

DOB _____ Age _____ Height _____ Weight _____ Gender M F

Primary Diagnosis:_____

Secondary Diagnosis:_____

Mobility status (walks unassisted, assistive devices, etc.)_____

Communication (verbal, non-verbal, signs)_____

_____

Behaviors (Impulsive, fearful, frustration tolerance)_____

_____

_____

_____

Medications Taken_____

_____

_____ Seizures (if applicable please describe)_____

_____

Limitations_____

_____

Allergies_____

_____ Skin sensitivity_____

_____

Personal Goals (fill in the areas that apply, can be added to later)

Physical_____

_____

_____

Cognitive_____

_____

_____

Social/Behavioral_____

_____

Emotional_____

_____

_____

Other_____

_____

_____

Availability for the Program (check all available times and days)

Monday am____Tuesday am____ Wednesday am____ Thursday am____ Friday am____

Monday pm___ Tuesday pm____ Wednesday pm____ Thursday pm ____ Friday pm___

Start Date:_____

Contact Information

Participant Name:_____

Address:_____

_____

City/State/Zip:_____

Contact Phone:_____ Preferred

Email Address:_____ Names of

parents/guardian (if minor):

Father:_____ Cell:_____

Mother:_____ Cell:_____ Emergency

Contacts:

Name:_____

Phone:_____

Name:_____

Phone:_____

How were you referred to Therapeutic Riding?_____

_____

Participant Liability Release, Confidentiality Agreement, Photo and Video Release

Participant Name:_____ Date:_____

Liability Release:

Name of Parent/Legal Guardian/Conservator_____

I acknowledge the risks and potential risks for horseback riding and activities in and around a facility where horses are kept and farm machinery operated. However, I feel that the possible benefits to me/my son/my daughter/my ward are greater than the risk assumed. Intending legally to bind myself, my heirs, and assigns, executors or administrators, I hear by waive and release forever all claims for loss or damages of any kind against Instructor Laura Seibert, Board of Directors, Volunteers, Therapists, Aids and employees of any and all injuries and losses that I/my son/my daughter/my ward may sustain while participating in this Therapeutic Riding Program. I engage in activities voluntarily with knowledge of the risks and I assume all risk of injury, death, and property damage that may result. I agree to bear any loss myself. I acknowledge that Laura Seibert and the property owners are materially replying on this waiver and assumption of risk in allowing me/my son/my daughter/my ward to participate in activities at this facility.

Date:_____

Signature:_____ (Participant,

Parent or Caregiver)

Photo and Video Release:

_____I consent to authorize

_____I do not consent to nor do I authorize

The use and reproduction of any audio/video materials taken of me/my son/my daughter/my ward. For distribution to the public, for promotional printed materials, educational activities, or for any other use for the benefit of the program.

Date:_____

Signature:_____ (Participant,

Parent of Caregiver)

Possible Reason for Participant Discharge

1. The client has reached all of their goals and is ready to graduate.
2. The client's potential to maintain head and neck control while riding presents a safety concern.
3. Inability to follow directions is interfering with progress toward goals.
4. Uncontrolled and/or inappropriate behavior that constitutes a safety risk to client, staff and/or horse.
5. Client exceeds weight that can safely managed by staff, volunteers and/or horses.
6. Any change in the client's medical, physical, cognitive or emotional condition that makes therapeutic riding inappropriate.
7. Three scheduled appointments are missed without prior cancelation.
8. Non-payment of fees as originally agreed.
9. Caregiver/family member/sibling presents disruptive or otherwise inappropriate behavior while on premises.

I understand and agree with the possible reasons for client discharge.

Signature of Participant or Legal Guardian:_____

Date: _____

Barn Rules

1. Shoes must be worn at all times at the facility
2. No running near the horses
3. Only services animals may accompany guests
4. Please do not hand feed horses and ask which ones may be pet
5. Horses will be mounted and ridden in arena or round pen only
6. Children under 14 must be accompanied by an adult to handle any horse
7. Helmets will be worn by minors and are highly recommended for adults when in arena
8. If you open a gate or door, close it behind you
9. Do not open gates or doors unless you have been instructed to do so
10. No smoking on the premises
11. Place your trash in designated cans
12. Riders and guests must sign a liability release before handling any horse
13. No climbing on gates, fences or railing
14. Therapy horses will be properly groomed and cooled before and after all use
15. Do not borrow any tack, tools, or any other items without asking
16. No cussing, please
17. Be kind and respectful to all animals and humans present
18. Encourage one another and help us keep our horses healthy and happy

Rules are in place for the safety and enjoyment of our guests, horses, volunteers, and staff. If you do not understand any of the rules, please any staff member to clarify. We would be happy to do so. Repeated failure to adhere to the rule will result in being asked to leave the premises. Any guest or participant expelled from any program due to bad behavior will not receive a refund for lessons remaining in the session.

I, _____, have read and understand the rules and commit to follow them.

Information for Physician

Dear Health Provider:

Your patient,_____, 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 Form.

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. **Please complete the Medical Release and Health History Assessment forms. Also, please note if any of the following conditions are present, and to what degree.**

Orthopedic

- Spinal Fusion
- Spinal instabilities/abnormalities
- Atlantoaxial Instabilities
- Scoliosis
- Kyphosis
- Lordosis
- Hip Subluxation and Dislocation
- Osteoporosis
- Pathological Fractures
- Coxas Arthrosis
- Heterotopic Ossification
- Cranial Deficits

Medical/Surgical

- Severe Allergies
- Poor Endurance
- Cancer
- Recent Surgery

Secondary Concerns

- Behavior Problems
- Age under Two Year
- Age Two to Four Years
- Indwelling Catheter
- Acute Exacerbation
- Of Chronic Disorder
- Diabetes
- Peripheral Vascular Disease
- Varicose Veins
- Hemophilia
- Hypertension
- Serious Heart Condition
- Stroke (Cerebrovascular Incident)
- Internal Spinal Stabilization Devices Spinal Orthoses

Neurological

- Hydrocephalus/Shunt
- Spina Bifida
- Tethered Cord
- Chiari II Malformation
- Paralysis due to Spinal Cord Injury
- Seizure Disorders

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant:_____ DOB:_____ Height:_____ Weight:_____
Address:_____
Diagnosis:_____ Date of Onset: _____
Past/Prospective Surgeries:_____
Medications:_____
Shunt Present: Y /N Date of Last Revision:_____
Special Precaution/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: Pos Neg
PATH recommends within the past 5 years and review every year; Physician Discretion for repeat x-ray.
Neurologic Symptoms of Atlanto AxialInstability:_____

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

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disabilty			
Cognitive			
Emotional/psychological			
Pain			
Other			

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

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

Signature:_____ Date:_____
Name:_____ _____
Address:_____ Title: MD DO NO PA Other
Phone: (_____) License/UPIN Number:_____

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 me at 208-553-3590

Sincerely,

Laura Nass-Executive Director

NO CALL/NO SHOW POLICY

WHEN YOU ENROLL AT FREEDOM HOOVES THERAPEUTIC RIDING CENTER, we schedule you on a regular basis and a horse is prepared prior to each lesson. We also schedule staff and volunteers to meet the need of the class (both in individual and group).

Please call **24** hours in advance if you will **NOT** be able to attend your lesson. This helps us to adjust our program, volunteers and horses for the lessons if needed. If you cannot call 24 hours in advance, please make sure you call by 8:00 a.m. We will take into consideration emergencies, but **PLEASE CALL US.**

If you are more than 10 minutes late for your scheduled class you will NOT be able to ride. Please arrive on time. If you are consistently late we will need to discuss a different time that is more suitable.

All No Call/NO Show absences will be charged the full lesson fee. After three (3) No Call/No Shows you will be dropped from your class and will have to re-register. If you are on a full or partial scholarship, you will have to reapply.

Thank you for informing us of your unavailability for your scheduled lesson. We appreciate your understanding and support.

By signing below I agree that I have read and understand NITHR's No Call/ No Show policy.

Participant Name:_____

Parent/Participant Signature:_____ Date:_____