



PARTICIPANT APPLICATION



(Please Print)

Participant: _____ Date: _____

These times do not necessarily reflect actual class schedule. Please check all times that the rider would be available to ride. Mark three preferred times with a 1, 2, or 3. The more options checked increases the likelihood of class placement.

| <u>Wednesday</u> | <u>Friday</u> | <u>Saturday</u> |
|------------------|---------------|-----------------|
| ___ 9 a.m. | ___ 9 a.m. | ___ 9 a.m. |
| ___ 10 a.m. | ___ 10 a.m. | ___ 10 a.m. |
| ___ 11 a.m. | ___ 11 a.m. | ___ 11 a.m. |
| ___ 12 p.m. | ___ 12 p.m. | ___ 12 p.m. |
| ___ 3 p.m. | | |
| ___ 4 p.m. | | |
| ___ 5 p.m. | | |
| ___ 6 p.m. | | |

PARTICIPANT PROFILE:

- Have you/your child participated with Riding Unlimited before: Yes ___ No ___
If yes, how many sessions ___; beginning year ___
- Have you/your child participated with another therapeutic riding program: Yes ___ No ___ If yes, how long ___
- I/My child is: ambulatory ___ non-ambulatory ___ verbal ___ non-verbal ___
- I/My child uses: wheelchair ___ crutches ___ braces ___ walker ___ cane ___
- I am/My child sits independently: Yes ___ No ___ I/my child has head control: Yes ___ No ___
- How did you hear about the program: _____

Tuition: 10 week fall and spring session: \$350 (choice of full or three scheduled payments)
 5 week summer session: \$175
 5 week winter session: \$175

Make checks payable to: *Riding Unlimited*
 Mail to: Riding Unlimited
 Participant Registration
 9168 T. N. Skiles Rd.
 Ponder, TX 76259-5823

(payable with cash, check or charge)

***Do not send a tuition payment until
you are assigned to a class.***

I would like to apply for financial assistance: Yes ___ No ___

For more information or to make payment arrangements, contact the Riding Unlimited Director at (940) 479-2016.

OFFICE USE ONLY:

Date Received _____ Application Complete: _____
 Check #: _____ Check Amount: _____

Change of address?

Riding Unlimited



Therapeutic Horsemanship for the Disabled

Update: _____
Initial: _____
Date: _____

Participant Registration and Release Form

REGISTRATION:

Today's Date: _____

Participant: _____ Date of Birth: _____

Street: _____ City: _____ State: _____

Zip Code: _____ County: _____ E-mail address: _____

Home Phone: (____) _____ Work Phone: (____) _____ Emergency: (____) _____

Parents/Legal Guardian/Adult Caregiver: _____

Address: _____ Phone: (____) _____

Second Parent/Guardian/Caregiver address if different from above: _____

(Street) (City) (State) (Zip)

Employer/School: _____

Ethnic Background (Optional)

- American Indian or Alaskan Native
- Asian or Pacific Islander
- Black/African-American
- Hispanic/Latino (including Mexican-American and Puerto Rican)
- White, Anglo, Caucasian (non-Hispanic)
- Multiracial (please specify): _____

LIABILITY RELEASE:

_____ (**Participant's Name**) would like to participate in the Riding Unlimited program. I acknowledge the risks and potential risks of horseback riding. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs, and assigns, executors or administrators, waive and release forever all claims for damages against Riding Unlimited, its Board of Directors, Instructors, Therapists, Aides, Horse Owners, Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Riding Unlimited programs.

WARNING - Under Texas law (Chapter 87, Civil Practice and Remedies Code), an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities.

Signature: _____ **Date:** _____
Participant, Parent, Legal Guardian

PHOTO RELEASE:

I hereby (**Check one**): **Consent** **Do NOT Consent**

to the use and reproduction by Riding Unlimited of any and all photographs and any other audio/visual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ **Date:** _____
Participant, Parent, Legal Guardian



Participant's Health History



To be completed by the participant or parent/legal guardian

Signature of person completing this form

Date

Diagnosis: _____

Date of Onset: _____

Please indicate current or past special needs in the following areas:

| | Y | N | Comments |
|-------------------------|---|---|----------|
| Vision | | | |
| Hearing | | | |
| Sensation | | | |
| Communication | | | |
| Heart | | | |
| Breathing | | | |
| Digestion | | | |
| Emotional/Mental Health | | | |
| Behavioral | | | |
| Pain | | | |
| Bone/Joint | | | |
| Thinking/Cognition | | | |
| Allergies | | | |
| Other | | | |

MEDICATIONS (include prescription, over-the-counter; name, dose and frequency): _____

Describe your/your child's 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 including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

GOALS (i.e. Why are you applying for participation? What would you like to accomplish?)

Authorization for Emergency Medical Treatment Form

Participant **Staff** **Volunteer**

Name: _____ DOB: _____

Parent/Guardian (if applicable): _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Physician's Name: _____ Preferred Medical Facility: _____

Insurance Carrier: _____ Policy Number: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Describe any medical conditions requiring special precautions or treatment. None or describe:

Consent Plan

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 Riding Unlimited 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.

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 above is unable to be reached.

Date: _____ Consent Signature: _____

Participant, Parent or Legal Guardian

----- **OR** -----

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 service or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures take place:

- Parent or legal guardian will remain on site at all times during equine assisted activities.
- In the event emergency treatment/aid is required, I wish the following procedure to take place

Date: _____ Non-Consent Signature: _____

Participant, Parent or Legal Guardian

GETTING TO KNOW YOU

Please fill out this page for our *Getting to Know You* notebook.
The notebook is for the volunteers to get to know a little about the students they will be working with.

Date

PICTURE

My full name is _____.

Please call me _____ My birthdate is _____
(name I go by)

I started at Riding Unlimited on _____
(date)

My interests or hobbies are _____.

Brothers, sisters, pets? _____.

My goals for riding therapy are _____.

Please supply any details you think might be helpful to the volunteers who will be working with him/her/you.

Speech _____ Comprehension _____

Vision _____ Hearing _____

Ambulatory Status _____

Particular methods he/she/you responds to _____



Riding Unlimited
Therapeutic Horsemanship for the Disabled

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 the attached Medical History and Physician's Statement Form. Please note that the following condition 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 Instabilities – including neuralgic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint Subluxation/Dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

Neurologic

Hydrocephalus/shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other

Indwelling Catheters
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
Peripheral Vascular Disease
Recent Surgeries
Respiratory Compromise
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 activities, please feel free to contact the center at the address/phone indicated below.

Sincerely,

Mary Gwinner

Mary Gwinner
Riding Unlimited
Executive Director
940-479-2016
ridingunlimited@aol.com

Participant's Medical History and Physician's Statement

Participant: _____ Date of Birth: _____ **Height:** _____ **Weight:** _____

Address: (Street) _____ (city) _____ (St.) _____ (Zip) _____

Diagnosis: _____ Date of Onset: _____

Current Medications: _____ For: _____

Past/Prospective Surgeries: _____

Shunt Present: Y N Date of last revision: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____

Special Precautions/Needs: _____

Mobility: Independent Ambulation: Yes No Assisted Ambulation: Yes No Wheelchair: Yes No

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:

| Areas | Yes | No | Comments |
|-------------------------|-----|----|--|
| Auditory | | | |
| Visual | | | Vision without correction: Vision corrected to: |
| Tactile Sensation | | | |
| Speech | | | |
| Cardiac | | | |
| Circulatory | | | |
| Integumentary/Skin | | | |
| Immunity | | | |
| Pulmonary | | | |
| Neurologic | | | |
| Muscular | | | |
| Balance | | | |
| Orthopedic | | | |
| Asthma | | | |
| Allergies | | | |
| Learning Disability | | | |
| Cognitive | | | |
| Emotional/Psychological | | | |
| Pain | | | |
| Other | | | |

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the NARHA 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: _____ License/UPIN #: _____ **Date:** _____ Phone: (____) _____