



## 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: \_\_\_\_\_



Therapeutic Riding and Carriage Driving Center

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)

- Checkboxes for American Indian or Alaskan Native, Asian or Pacific Islander, Black/African-American, Hispanic/Latino, White, Anglo, Caucasian, and Multiracial.

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: \_\_\_\_\_

Participant, Parent, Legal Guardian

Date: \_\_\_\_\_

PHOTO RELEASE:

I hereby (Check one):

Consent checkbox

Consent

Do NOT Consent checkbox

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: \_\_\_\_\_

Participant, Parent, Legal Guardian

Date: \_\_\_\_\_



# 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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## Therapeutic Riding & Carriage Driving Center

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: (\_\_\_\_) \_\_\_\_\_