****

**RISING HOPE THERAPEUTIC RIDING CENTER**

**PARTICIPANT**

**REGISTRATION FORM**

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: **M F**  Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_

Home#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work#\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation/School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is participant over 21, legally competent and able to sign for him/herself?  **Yes    No**

If **no,** legal guardian, not the participant, must sign all documents.

**PHOTO AND VIDEO RELEASE**

**I Consent\_\_\_\_\_ I Do not Consent\_\_\_\_\_(please check one)** to and authorize the use and reproduction by Rising Hope Therapeutic Riding Center, Inc. of any and all photographs and any other audio-visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature of Participant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_

                                                           (Signature of participant, parent or guardian)

**Participant Authorization for**

**Emergency Medical Treatment Form**

**PARTICIPANT INFO:**

First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Medical Facility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Insurance Co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State any information that you want supplied to a medical professional treating you in an emergency:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**In the event of an emergency, contact:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 premises operated by Rising Hope Therapeutic Riding Center, Inc., I **authorize** Rising Hope Therapeutic Riding Center, Inc. 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 below is unable to be reached.

Consent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

                                   Signature of Volunteer or Parent/Guardian

**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 receiving services or while being on the property of the agency.

**Must Check one of the following:**

**\_\_\_\_\_\_** A 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 procedures to take place:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Non-Consent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Rising Hope Waiver and Release**

**MUST** Release: All Visitors, Participants, Volunteers (or Parent or guardian if under 21) **SIGN THIS RELEASE , WAIVING LEGAL RIGHTS AGAINST RISING HOPE THERAPEUTIC RIDING CENTER AND CYNTHIA** **LAMEY.** If you do not sign a Release, you will not be permitted on the properties.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a visitor to /participant of/volunteer in/the Rising Hope Therapeutic Riding Center equine assistance program (the “Program”) or the parent or legal guardian of a visitor to /participant of/volunteer in/ the Program, am aware that all activities involving horses, including but not limited to riding, driving, grooming, leading, and/or any events involving horses, pose many inherent dangers, risks, and hazards. These include, but are not limited to, bodily injury and physical harm to riders, instructors, therapist, aides, groomers, leaders, handlers, side walkers, photographers, spectators and /or any other helpers. I freely and fully assume all dangers, risks, and hazards and the possibility of injury, death, property damage or other loss resulting from such dangers, risks, and hazards. I understand that I or my child or ward should not participate in the Program or visit the properties unless medically able. I agree to comply with Program rules and regulations, directions, instructions, and/or safety precautions given by Program employees, instructors, therapists, aides, and volunteers. My or my child’s or ward’s participation in the Program or visit to the properties is upon the express agreement and understanding that I have received, read, and understand the Waiver and Release.

In consideration of my or my child or ward’s participation/volunteering in the Program or visit to the properties, I hereby, for myself and any participant for whom I am a parent or  legal guardian release, discharge, hold harmless, and forever acquit Rising Hope Therapeutic Riding Center together with its officers, directors, agents, representatives, employees, instructors, therapists, aides, and volunteers, and Cynthia Lamey, in her individual capacity, and groom any and all actions, causes of action, losses, claims, or any liabilities whatsoever including but not limited to illness or injury known or unknown now existing or which may arise in the future, which may accrue to me, my heirs, my guardians, administrators, executors, or assignees, including attorney’s fees and court costs, on account of or in any way related to or arising out my or my child or ward’s participation in the Program or visit to the properties. Finally, assume all liability of any non-participants who accompany me.

I have had the opportunity to ask any questions that I may have and such questions have been answered to my satisfaction. I have read, understood and agree to the above. I understand and confirm that by signing this Waiver and Release that I have given up considerable future legal rights. My signature is proof of my intention to execute a complete and unconditional Waiver and Release of all liability to the full extent of the law.

Participant/Volunteer/Visitor’s Name Printed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant/Volunteer/Visitor’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_

**AGREEMENT AND CONSENT OF PARENT OR GUARDIAN OF MINOR**

I, as the parent of guardian of the above visitor or participant, give my permission for my child or ward to participate in the Program or visit the properties.  And further, in consideration of allowing my child or ward to participate in the Program or visit the property, I agree individually and on behalf of my child or ward to the terms of the above Waiver and Release.

Participant/Volunteer/Visitor’s Name Printed

Date

Participant/Volunteer/Visitor’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_

**PAYMENT POLICY AND SCHEDULING**

Therapeutic Riding lessons are planned with the individual’s educational, physical, social, and/or recreational goals in mind and are taught by a PATH Intl. Certified Registered Instructor. Lessons may include warm-up exercises, skill development, and activities or games to reinforce goals. Classes are approximately **45** minutes in length and may include time for grooming, tacking, and ½ hour of riding dependent upon the participant’s abilities. Classes may be group or individual depending on rider needs and schedule availability. Rising Hope is offering 3 sessions for the 2018 calendar.

\*\* **Lesson fees are expected prior to lessons and may be paid in advance with no exceptions.**

Lesson fees: **$40/session (All additional sibling’s fees will be $30/session)**

**Scholarship Program:** Again, this year there is a limited scholarship program. Please request an additional scholarship application if interested in partial or full scholarship.

We ask for cancellations at least 24 hours in advance, and only lessons cancelled at least two (2) hours in advance are eligible for a make-up. Lesson credit or refunds will not be given to more than 1 cancellation. **While we do know that emergencies happen, we hope that you understand that your lesson fee supports our horses and allows us to continue to achieve our mission.**

Classes may be cancelled due to inclement weather. All efforts will be made to contact participant within two hours of scheduled lesson time. For some participants and situations, an option may be that a stable horsemanship class can occur indoors. Lessons may be canceled if the wind chill reaches **30** degrees or below, or if the heat index reaches **90** degrees or higher.  Cancellations because of inclement weather will be credited if make-up is not possible.

**SCHEDULING**

     Please check **2020** sessions of interest

**\_\_\_Spring** March 30 - May 22 (8 weeks weather permitting)

\_\_Mon. am or pm   \_\_Tues. am or pm \_\_Wed. am \_\_ Thurs. am or pm  \_\_ Fri. am

**\_\_\_ Summer** June 08 – August 14 (10 weeks)

\_\_Mon. am or pm   \_\_Tues. am or pm \_\_Wed. am \_\_ Thurs. am or pm  \_\_ Fri. am

\_\_\_ **Fall** Sept 07 -Nov 13 (10 weeks)

\_\_Mon. am or pm   \_\_Tues. am or pm \_\_Wed. am \_\_ Thurs. am or pm  \_\_ Fri. am

**CLOSED:  Independence Day, Veterans Day & Memorial Day**

**Rising Hope Therapeutic Riding Center**

**Policies and Procedures**

**Limitations**

The current minimum age to participate in the program is 4yrs.

It takes a special horse to become a part of the Rising Hope herd. Horses must demonstrate that they have the high level of patience, tolerance and the steady rhythmic gait required to be a good therapy horse. And like people, no two horses are alike.  Each offers specific benefits to our riders, with their own needs and limitations. Therefore, it is critical that we do not exceed each horse’s weight limit and work schedule.

**Clothing**

Equestrian activities require certain attire. Participants must wear long pants such as riding breeches or jeans to prevent chafing of legs. Footwear should consist of shoes or boots with a rounded toe and small heel. Riding boots with a heel must be worn when saddles without safety stirrups are used.  Sandals, clogs or slip-on shoes are unacceptable. Parents or caregivers that accompany the participant to the farm are asked to wear appropriate footwear also. No jewelry is permitted. Safety helmets that meet ASTM-SEI requirements are required to be worn by all participants. Helmets will be available, but it is suggested that participants acquire their own helmet.

**Safety and Conduct for Participants & Visitors**

Rising Hope supports all efforts to promote safe conditions at its facility. Working with horses is a high risk activity. The following rules must be adhered to at all times:

• Participants are required to use gentle hands and feet while on or near any horse.

• Running, yelling, abusive or aggressive actions are not tolerated.

• No one may enter the paddock areas or stalls without permission from a staff member.

• Appropriate attire and footwear (no sandals) are required in barn and paddock areas.

• Hand-feeding of the horses is not allowed under any circumstance.

• Photography or video are not allowed without permission from staff.

• Children must be supervised by an adult at all times.

• No pets are allowed on the grounds.

• Smoking, alcohol or illegal substances are not allowed on the premises.

• Please respect that Rising Hope is located at a private farm and understand that the

house is off-limits.

• Participants are only permitted on property during hours of operation.

• All visitors must sign a waiver/release form and remain in designated visitor areas

• Weapons and firearms are not allowed on RH private property

**I have read and understand all Rising Hope TRC policies and procedures:**

**Signature of Participant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_**

**(Signature of participant, parent or guardian)**

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**RISING HOPE PARTICIPANT QUESTIONNAIRE**

***Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

1. Briefly describe his/her disability:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What are the physical symptoms of the disability?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3.** What goals do you hope he/she will achieve by participation in this program:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What other treatments or therapies has he/she undergone? Please specify when and for how long:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5.** How would you describe his/her concentration, attention span and general awareness:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6.** Would you characterize him/her as happy, aggressive, easygoing, enthusiastic, passive excitable depressed, introverted or extroverted:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7.** Is he/she able to understand language? How does he/she communicate?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8.** Is there a history of incontinence?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9.** What positive reinforcements does he/she respond to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10.**  Please indicate any other areas of behavior and personality that will help us best communicate, understand and work with him/her.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

****

**MEDICAL HISTORY AND PHYSICIAN’S RELEASE-MUST BE COMPLETED BY PHYSICIAN**

|  |
| --- |
| Name: |
| DOB:                                                   Height:       Weight: |
| Address: |
| Name of Parent or Guardian: |
| Primary Diagnosis:                                                                                           Date of Onset: |
| Secondary Diagnosis:                                                                                       Date of Onset: |
| Shunt Present:   Yes No   Date of last revision: |
| Seizure Type:                                Controlled: Yes No Date of last Seizure: |
|  |

**PLEASE LIST ALL CURRENT MEDICATIONS**

|  |  |
| --- | --- |
| 1. | Taken for: |
| 2. | Taken for: |
| 3. | Taken for: |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Please indicate if patient has a problem and/or surgeries in any of the following areas.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Areas** | **Yes** | **No** | **Comments** |
| Auditory |  |  |  |
| Visual |  |  |  |
| Speech |  |  |  |
| Cardiac |  |  |  |
| Circulatory |  |  |  |
| Pulmonary |  |  |  |
| Neurological |  |  |  |
| Muscular |  |  |  |
| Orthopedic |  |  |  |
| Allergies |  |  |  |
| Learning Disabilities |  |  |  |
| Mental Impairment |  |  |  |
| Psychological Impairment |  |  |  |
| Incontinence |  |  |  |
| Coordination |  |  |  |
| Balance |  |  |  |
| Independent Ambulation:    Yes No | | | Crutches/Cane    Yes No |
| Wheelchair:     Yes No | | | Braces:     Yes No |
| Past/Prospective Surgeries: | | |  |
| Special Precautions/Needs: | | |  |

**PHYSICIAN INFORMATION**

|  |  |
| --- | --- |
| The following conditions, if present, may represent precautions and contraindications to the therapeutic horse riding. Please be sure to clearly identify and check the boxes if any of the following conditions are present and explain to what degree. | |
| **Orthopedic** | **Medical/Surgical** |
| Atlantoaxial instabilities | Allergies |
| Coxas Arthrosis | Cancer |
| Cranial Deficits | Diabetes |
| Heterotopic Ossification | Hemophilia |
| Hip Subluxation and Dislocation | Hypertension |
| Internal Spinal Stabilization Devices | Peripheral Vascular Disease |
| Kyphosis | Poor Endurance |
| Lordosis | Recent Surgery |
| Osteogenesis Imperfecta | Serious Heart Condition |
| Osteoporosis | Stroke |
| Pathologic Fractures | Varicose Veins |
| Scoliosis |  |
| Spinal Fusion |  |
| Spinal Instabilities/Abnormalities |  |
| Spinal Orthoses |  |
|  | **Neurologic** |
| **Secondary Concerns** | Tethered Cord |
| Acute exacerbation of chronic disorder | Chiari II Malformation |
| Behavior problems | Hydrocephalus/shunt |
| Indwelling catheter | Hydromyelia |
| Integumentary/Skin | Paralysis due to Spinal Cord Injury |
|  | Seizure Disorders |
|  | Spina Bifida |

**PARTICIPANTS WITH DOWN SYNDROME –PLEASE NOTE AND COMPLETE**

|  |
| --- |
| Due to the nature of the activity of horseback riding, no individual diagnosed with Down Syndrome can be accepted for riding instruction without proof of a negative diagnostic  x-ray for Atlantoaxial instability. Please provide the following information: |
| Most recent cervical x-ray for AAI:               \_\_\_\_Positive \_\_\_\_\_Negative Date of x-ray |

**PHYSICIAN VERIFICATION-PLEASE PRINT YOUR NAME, SIGN AND DATE**

**THANK YOU!**

|  |
| --- |
| To my knowledge, there is NO REASON why this person cannot participate in supervised equestrian activities. However, I understand that Rising Hope will weigh the medical information above against the existing precautions and contraindications. |
| Physician Name/Title (Print) |
| Signature:                                                                             Date: Phone: |
| Address: |