Healing Reins of Kentucky, Inc.
2023 Participant Application

Updated 1/2023

Applicant Name: _____ Check: □ Male □ Female

Age:_____ Date of Birth:___/_____/____ Employer/School:_____

Legal Guardian/Parent:

Name:_____Relation:_____

Address: _____ City/State/Zip:_____

Home Phone:_____ Cell Phone:_____

Address:_____City/State/Zip:_____

Email:_____Employer: _____

For scheduling purposes, please list your 1st and 2nd choice for weekly lessons during a session. All sessions **must be paid in full before the start**.

1. Day (M –F) _____ Times: (9am to 6pm) _____
2. Day (M –F) _____ Times: (9am to 6pm) _____

I have and will inform Healing Reins of any medical updates or changes when they occur.

I have read and **agree to** the attached **Rider Weight Limit Policy**. I hereby **consent** for the above information to be maintained in the Healing Reins of Kentucky, Inc. database so that I may receive information about the program. Your information will not be shared with outside organizations.

Legal Guardian Signature:_____**DATE:**_____

Photo and Video Consent

I **DO**_____**DO NOT** _____consent to, and authorize the use and reproduction by Healing Reins of Kentucky, Inc. (HR) of any and all photographs, video/audio materials taken of me for the purpose of on-going studies, educational activities, exhibitions, promotional materials or for any other use for the benefit of the program.

Legal Guardian Signature:_____**DATE:**_____

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Liability Release

_____(Participant's name) would like to participate in Healing Reins of Kentucky, Inc. programs. I acknowledge the risks and the potential for risks of horseback riding, hippotherapy and horse related activities and therapies. However, I feel 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, known and unknown whether existing on the date of the agreement or in the future, against Healing Reins of Kentucky, Inc., Blue Moon Stables, LLC, Rolling Hills Equestrian Center, their Board of Directors, Employees, Instructors, Therapists, Aides, Volunteers, Equines, Equine Owners, Equipment and Operating Site for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating at Healing Reins of Kentucky, Inc.

*WARNING Under Kentucky law, a farm animal activity sponsor, farm animal professional, or other person does not have the duty to eliminate all risks of injury of participation in farm animal activities. There are inherent risks of injury that you voluntarily accept if you participate in farm animal activities.

Legal Guardian Signature:_____**DATE:**_____

Emergency Medical Information:

Participant Name: _____

Physician Name:_____

Allergies:_____

Current Medications: _____

I would want Emergency responders to know: _____

_____

Emergency Contacts:

Name: _____Relation:_____Phone: (____)_____

Name: _____Relation:_____Phone: (____)_____

Name: _____Relation:_____Phone: (____)_____

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Applicant's Medical History:

Diagnosis:_____Date of Onset:_____

***Required for Down Syndrome: An annual medical clearance from a licensed physician that includes a neurological exam that specifically denies any symptoms consistent with atlantoaxial instability (AAI) is required.**

Seizures:_____Type:_____Controlled: Yes_____No:_____Date of last seizure:_____

Current Height:_____Current Weight:_____Date of Last Tetanus Shot:_____

Shunt Present: Yes_____No____ Date of last revision:_____ History of animal abuse: Yes_____No_____

Indicate current or past special needs/concerns/surgeries with an X beside Y or N. If yes, please comment.

____Y____N Auditory:_____

____Y____N Visual:_____

____Y____N Tactile Sensation:_____

____Y____N Speech:_____

____Y____N Cardiac:_____

____Y____N Circulatory:_____

____Y____N Integumentary/Skin:_____

____Y____N Digestion:_____

____Y____N Elimination:_____

____Y____N Immunity:_____

____Y____N Pulmonary:_____

____Y____N Neurological:_____

____Y____N Muscular:_____

____Y____N Balance:_____

____Y____N Orthopedic:_____

____Y____N Allergies:_____Epi-Pen?_____

____Y____N Learning Disability:_____

____Y____N Cognitive:_____

____Y____N Emotional/Psychological:_____

____Y____N Behavioral:_____

____Y____N Pain:_____

____Y____N Other:_____

Describe Mobility i.e. independent ambulation, assisted ambulation, wheelchair, braces: _____

_____

Additional Medical Information:_____

To the best of my knowledge the medical history is true and accurate:

Legal Guardian Signature:_____DATE:_____

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Rider Weight Policy- P*lease read*

Healing Reins of Kentucky, Inc. (HR) will adhere to the following guidelines when making decisions regarding rider weight. Each guideline is in place so that every member of the team (horse, rider and volunteer) may have a safe experience. Horse health, rider's weight distribution, rider's ability to dismount without hurting the horse and each volunteer's ability to safely assist a rider are all very important considerations. **Rider may be weighed on-site at intake or first lesson or when deemed necessary during a session.**

- Each horse will be evaluated as an individual and assigned a maximum carrying weight. Considerations will be made for age and health/soundness.
- Each rider will be evaluated as an individual. Considerations will be made for rider's height, range of motion, balance and ability to dismount independently.
- Each team will be evaluated to ensure that an appropriate volunteer/instructor is available to complete all emergency procedures including an emergency dismount.
- In general, the following rider height to weight ratios will be followed:

Rider Height	Maximum Weight
Under 5'0" tall	150 lbs.
5' to 5'6" tall	175 lbs.
5'7" to 6' tall	200 lbs.
6'1" to 6'5" tall	250 lbs.

- The maximum amount of weight each horse can carry is determines using the following formula:
  - 20% of the horse's weight minus the weight of tack minus 10 pounds for degrees of unbalanced rider movement. (Unbalanced rider movement is determined through instructor observation while rider is mounted and thorough balance exam while non-mounted.) Other considerations are: observation of equine movement while carrying weight, and veterinary input.
- Each horse has a maximum number of lessons they may participate in per week. Therefore the number of horses available to carry higher weights may be limited.
- If, after an evaluation, a rider is determined to be over the weight limit of any available horse, the participant has the option to participate in other programs, such as unmounted therapeutic horsemanship.

Riders may be asked to weigh-in on HR scales at any point during their riding sessions.

Return To:
Healing Reins of Kentucky, Inc.
PO Box 2027, Henderson, KY 42419
Or Email application to horsesheal1@gmail.com

www.HealingReinsKY.org

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Physician Form- Physician's office MUST complete

Dear Healthcare Provider: Your patient _____is interested in participating in supervised equestrian activities. In order to safely provide this service, our operating center requests that you complete/update the Medical History & Physician's Statement. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree. If you have any questions or concerns regarding the patient's participation in therapeutic horseback riding, hippotherapy and horse related activities, please do not hesitate to contact the operating center.

***Required for Down Syndrome: Neurologic Symptoms of Atlantoaxial Instability: Present___Absent___Date____**

***An annual medical clearance from a licensed physician that includes a neurological exam that specifically denies any symptoms consistent with atlantoaxial instability (AAI) is required.**

Patient weight during last exam_____ Height_____ Date of Exam_____

The following conditions, if present, may represent precautions and contraindications to therapeutic horseback riding.

Please circle below any of the following conditions present:

Orthopedic
Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation & Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Neurologic
Acute exacerbation of chronic disorder
Hydrocephalus/shunt
Chiari II Malformation
Spina Bifida
Tethered Cord
Hydromyelia
Paralysis due to Spinal Cord Injury
Seizure Disorders

Medical/Surgical
Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (CVA)

Secondary Concerns
Behavior Problems
Age less than two years
Age two-four years
Indwelling catheter
Weight Control Disorder
Substance Abuse
Danger to self or others
Thought Control disorder
Abuse of animals

Physician's Statement

Given the diagnosis and the medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl center for ongoing evaluation to determine eligibility for participation.

Physician Printed Name: _____Office Name:_____

License/UPIN Number:_____ Circle: MD DO NP PA or Other_____

Address/City/State/Zip:_____Phone:_____

Physician Signature: _____**Date:**_____

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Therapist/Teacher Questionnaire –*Optional*

Please provide as many as possible

Client Name: _____DOB: _____/_____/_____

Diagnosis: _____ Date of Request: ___/_____/_____

The above named client has applied for equine-assisted activities and therapy sessions at Healing Reins of Kentucky, Inc. So that we may design a program that best accommodates and benefits the participant, we would appreciate your input.

Therapist/Teacher name:_____Provider Type: _____

Address:_____City/State/Zip:_____

Email:_____Phone:_____

In what capacity do you work with the participant?

_____

_____

How long have you known the participant?

_____

_____

Do you have any information that will help us be more successful while working with the participant?

_____

_____

Do you have any specific goals for the participant that you feel Equine Assisted Services will help?

_____

_____

_____

Therapist/Teacher Signature: _____**DATE:**_____

Provider Type: _____ **License Number:**_____

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Demographic Information - *Optional, *Required if requesting financial assistance*

Healing Reins of Kentucky, Inc. is a non-profit organization supported by donations. We are frequently required to provide anonymous demographic information when applying for grants and other funding. **Your help is greatly needed.** Information will be kept confidential.

Please remember that participant fees cover a very small percentage of the cost to provide services. An important way you can help with fundraising it to provide us with this needed information to apply for grants and funding.

Participant Name: _____DOB:_____Age:____ Male:___Female:___

City and State of residence: _____ County of Residence:_____

Guardian Name: _____

How did you hear about our program?_____

Diagnosis_____

How long has the participant been coming to Healing Reins?_____

What is your relationship to the participant? SELF PARENT SPOUSE AIDE GUARDIAN

How many people live in the home with the participant?_____
Of this number, how many are under age 18?_____

What is the total annual income of the household? (Please place an X beside one)

_____Less than $15,000
_____Between $15,000 - $26,150
_____Between $26,150 - $29,500
_____Between $29,500 - $33,600
_____Between $33,600 - $37,350
_____Between $37,350 - $40,350
_____Between $40,350 - $43,350
_____Between $43,350 - $46,300
_____Between $46,300 - $50,000
_____Between $50,000 - $75,000
_____Between $75,000 - $100,000
_____Above $100,000

Occupation of Self, Parents or Guardians: _____

Please indicate the participant's ethnicity (needed for grant applications)

_____White/Caucasian
_____Asian/Pacific Islander
_____African American
_____Hispanic Origin
_____American Indian
_____Other_____
_____Mixed, please explain
_____
_____