



# Healing Reins of Kentucky, Inc. 2024 Participant Application



Updated 1/2023

Applicant Name: \_\_\_\_\_ Check:  Male  Female

Age: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Employer/School: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## Legal Guardian/Parent:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Employer: \_\_\_\_\_

For scheduling purposes, please list your 1<sup>st</sup> and 2<sup>nd</sup> 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: \_\_\_\_\_



# Healing Reins of Kentucky, Inc. 2024 Participant Application



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



# Healing Reins of Kentucky, Inc. 2024 Participant Application



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



# Healing Reins of Kentucky, Inc. 2024 Participant Application



## **Rider Weight Policy- Please 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 determined 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](mailto:horsesheal1@gmail.com)

[www.HealingReinsKY.org](http://www.HealingReinsKY.org)



# Healing Reins of Kentucky, Inc. 2024 Participant Application



## **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

**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

**Neurologic**

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

**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: \_\_\_\_\_



# Healing Reins of Kentucky, Inc. 2024 Participant Application



## **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?

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How long have you known the participant?

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

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

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Therapist/Teacher Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

Provider Type: \_\_\_\_\_ License Number: \_\_\_\_\_



# Healing Reins of Kentucky, Inc. 2024 Participant Application



## **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 only cover a 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 \$40,350 - \$43,350  |
| _____ Between \$15,000 - \$26,150 | _____ Between \$43,350 - \$46,300  |
| _____ Between \$26,150 - \$29,500 | _____ Between \$46,300 - \$50,000  |
| _____ Between \$29,500 - \$33,600 | _____ Between \$50,000 - \$75,000  |
| _____ Between \$33,600 - \$37,350 | _____ Between \$75,000 - \$100,000 |
| _____ Between \$37,350 - \$40,350 | _____ Above \$100,000              |

Occupation of Self, Parents or Guardians: \_\_\_\_\_

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

- |                              |                       |                             |
|------------------------------|-----------------------|-----------------------------|
| _____ White/Caucasian        | _____ Hispanic Origin | _____ Mixed, please explain |
| _____ Asian/Pacific Islander | _____ American Indian | _____                       |
| _____ African American       | _____ Other _____     | _____                       |