2017-2018 Participant Form

Rolling Hills Equestrian Center ● 7088 Old Corydon Rd ● Henderson KY 42420
Blue Moon Stables ● 8124 KY 268 ● Corydon KY 42420

Required for all programming, must be completed annually.

I am a new participant___ I am a returning participant____ Date of last participation_____

Applicant Name: _____ Check: ☐ Male ☐ Female

Age_____ Date of Birth:___/_____/____ Employer or School_____

Home Phone _____ Cell Phone _____Email _____

Address: _____City/State/Zip_____

Parent/Guardian/Caregiver: (Only need to complete if different than above)

Print Name:_____

Address: _____City/State/Zip_____

Home Phone _____ Cell Phone _____Email _____

Employer: _____

I hereby consent for the above information to be maintained in the HRTR database so that I may receive information about the program.

SIGNATURE: _____Date:_____

For scheduling purposes, please list your 1st, 2nd and 3rd choice for day and time for lesson. We will do our best to schedule your 1st choice. All lessons cost $25.

1. Day_____Times_____
2. Day_____Times_____
3. Day_____Times_____

Photo and Video Consent:

I DO_____DO NOT _____consent to and authorize the use and reproduction by Healing Reins 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.

SIGNATURE: _____Date:_____

Liability Release:

_____(Participant's name) would like to participate in Healing Reins Therapeutic Riding Program. 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 Therapeutic Riding, 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 Therapeutic Riding.

*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.

Signature: _____ Date:_____

Emergency Medical Information:

Name: _____

Physician's Name:_____

Preferred Medical Facility:_____

Health Insurance Company:_____

Policy #:_____

Allergies to Medications:_____

Current Medications: _____

I would want Emergency responders to know: _____

_____

Emergency Contacts:

Name: _____Relation:_____Phone: (____)_____

Name: _____Relation:_____Phone: (____)_____

Name: _____Relation:_____Phone: (____)_____

Participant Medical History

Diagnosis:_____Date of Onset:_____

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:_____Info:_____

Please indicate current or past special needs, concerns and/or surgeries in any of the following areas by typing an X beside yes or no. 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:_____

Y____N____ Learning Disability:_____

Y____N____Cognitive:_____

Y____N____ Emotional/Psychological:_____

Y____N____Behavioral:_____

Y____N____Pain:_____

Y____N____Other:_____

Describe Mobility (ex: independent ambulation, assisted ambulation, wheelchair, braces):_____

_____

Additional Medical Information:_____

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

SIGNATURE_____Date:_____

Physician's Medical Form – Must be completed by physician's office

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.

For persons with Down Syndrome: Neurologic Symptoms of Atlantoaxial Instability: Present_____Absent_____

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

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

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

Neurologic
Hydrocephalus/shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
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 Name (please print): _____

License/UPIN Number_____MD DO NP PA other_____

Address:_____Phone:_____

Physician Signature: _____ Date: _____

Therapist/Teacher Questionnaire

Please provide as many as possible

Client Name: _____ DOB: ____/___/_____ Age:_____

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

The above named client has applied for Therapeutic Horseback Riding Sessions at Healing Reins. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input.

Therapist/Teacher name:_____

Address _____

Email _____Phone_____

In what capacity do you work with the applicant?

How long have you known the applicant?

Any Helpful Hints for Working with This Person:

Do you have any specific goals for the applicant which you feel Equine-Assisted Activities will help the most?

Therapist or Teacher (Please Sign) _____
License Number_____Date _____/_____/_____

Demographic Information

Healing Reins Therapeutic Riding 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. Every participant must complete the following information. This information will be kept confidential and you may return this age separate from the other registration information,

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 HRTR with needed information to apply for grant and funding.

DOB:_____ Age:_____ Male:_____ Female:_____

State of residence: _____ County of Residence:_____

How did you hear about the program?_____

Diagnosis_____

How long has the participant been coming to HRTR?_____

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 19?___

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 (optional)_____

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
_____

Rider Weight Policy

HRTR 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.

- 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, 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 through 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 by at least two HRTR staff members, a rider is determined to be over the weight limit of any available HRTR horse, the participant has the option to participate in other HRTR programs, such as therapeutic horsemanship.

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

Return To:

Healing Reins Therapeutic Riding
PO BOX 2027
Henderson KY 42419

Can email application: horsesheal1@gmail.com

www.HealingReinsKY.org