Rider Enrollment Packet

Enrollment & Attendance Please fill out and sign the enclosed forms completely and return them to RIDE. A lesson time will be scheduled as soon as all forms are completed and an appropriate time slot is available.

Cancellation/ Make up policy: Please notify us if you will not be coming to your regularly scheduled lesson. If you give us at least 24 hours advance notice, we may be able to reschedule your lesson for a different day/time. However, rescheduled lessons are not garunteed and no refunds are given for lessons missed.

Program Fee Policy The current fee per session is $. Fees are due in advance of the session start day. If you need a payment plan please discuss with the program director on an available basis. Please give your payment to Dee or Stephanie.

Calendar of Riding Please see attached calendar of riding, RIDE runs on Mondays and Tuesdays June- August. RIDE will not occur if the weather is too severe or if it is not safe to ride at the discretion of the staff. Please contact is if you are unsure whether or not you attend.

Apparel Riding helmets are provided at the facility. Riders should dress appropriately for the current weather conditions. Please wear long pants and boots or sneakers (no sandals) for horseback riding.

RIDE is located at 2804 County Road 250 in Silt, CO 81652

Phone: 970-876-2987

Website: www.RIDEcolorado.org

Tax ID: 84-116-3848

Rider/Contact Information Sheet

Riders Information

Student's Name _____

Date of Birth _____ Gender: M F Weight _____

Current Diagnosis _____

Current Treatment/Services _____

Street Address _____

City _____ State _____ Zip code _____

Email _____

Rider is a (circle one): minor adult w/a legal guardian independent adult

Parent/Guardian Name _____ Cell Number _____

Occupation _____ Work Number _____

Other Parent/Guardian Name _____ Cell Number _____

Occupation _____ Work Number _____

Is either parent or guardian an active member of the military? Y N

Contact Information (used for scheduling, billing, newsletters, etc)

Person in charge of riders schedule/billing

Relationship to rider _____ Preferred phone number _____

Billing address (if different from above)

City _____ State _____ Zip Code _____

Primary Email _____

As a non-profit organization, we strive to keep our lesson fees reasonable. They cover 25% of the cost of the lessons. We rely heavily on a volunteer base to keep our program running. Is there any way you are willing to help RIDE?

_____

_____

_____

_____

Questionnaire & Health History

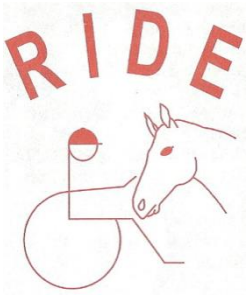
Has the student has previous experience with therapeutic riding? YES NO
If yes please explain…

Goals: What are you hoping to accomplish by participating in RIDE?

Comments: Please give any info that you feel will be helpful in lesson planning

Please answer the following to help s best prepare for your arrival and evaluation

Does the Student….	YES	NO	Comments
Walk independently			
Have poor balance sitting/standing balance?			
Have speech/language difficulties?			
Have problems with fine motor skills?			
Have problems with gross motor skills?			
Have allergies or breathing problems?			
Have pain?			
Have emotional/behavior problems?			
Have heart/circulatory problems?			
Have short term or long term memory loss?			
Have a fear of heights?			
Have a fear of horses or animals?			



Physician's Referral Form

To be signed and dated by current doctor

Patients name: _____

Patients Name and Contact# _____

Patient's date of birth: _____ Height: _____ Weight: _____

Medical History

Diagnosis: _____ Date of onset: _____

Primary Disability: _____

Other Concerns: _____

Hospitalizations: _____

Shunts/Assistive Devices: _____

Seizures/Allergies: _____

Present Medications: _____

Physical Examination

Skin/Circulatory _____ Neuro/Sensation _____

Heart/Lungs _____ Balance/Coordination _____

Bowel _____ Bladder _____

Vision _____ Hearing _____

Speech _____ Spasticity/Rigidity _____

Other _____

Precautions/Contraindications to Therapeutic Horseback Riding: _____

_____

_____

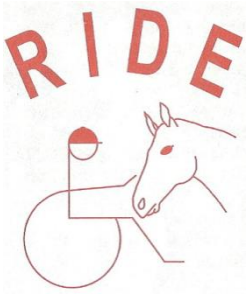
In my opinion this patient is able to receive therapeutic horseback riding instruction under appropriate supervision of RIDE

Physician's Signature _____ Date _____

Physician's Name _____ Phone _____

Office address _____

Parent/Guardian Signature _____ Date _____



Therapist Referral Form

If student is currently seeing a physical, occupational or speech therapist, please have them fill out this form and/ or attach a recent evaluation.

Name of student:_____ Birth Date: _____

Diagnosis:_____

Current Therapy: _____

Evaluations Used: _____

Short Term Goals:_____

Long Term Goals:_____

Objectives:_____

Areas of Weakness:_____

Areas of Strength:_____

Precautions:_____

Cues:_____

Other:_____

Therapist Signature_____ Date _____

Parent Signature_____ Date _____

Release of Liability Agreement

Name of Rider _____

Name of Parent _____

Address _____ City&Zip _____

Telephone Number _____

Emergency Contact _____

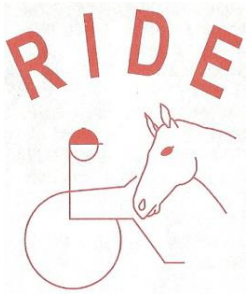
RIDE Therapuetic Horsemanship Program is professionally orientated and controlled. All staff, volunteers and horses have been carefully selected. Safety equiptment is used for all riders because horseback riding is a risk exercise.

No student can be accepted into the RIDE program until a parent or guardian has signed this form or, if the rider is of legal age he or she may sign. Therapuetic riding instruction will be under strict supervision and although every effort will be made to avoid any accident, NO LIABILITY can be accepted bt the organization or any persons connected with the organization.

The undersigned as self or parent/guardian of said minor_____, Herby agrees to hold harmless and indemnify RIDE, It's officers, trustees, agents, employees, volunteers, representatives, and succesors from all manner of liability, loss, costs, claims, demands, and damages of any kindand nature whatsoever, which is undersigned may now or in the future have against the said facility.

Date_____

Signed _____



Authorization for Medical Treatment

Name of Rider _____

Name of Parent _____

Rider's Date of Birth _____

Current Diagnosis _____

Current Medications _____

Allergies to Food/Medications _____

Date of Last Tetanus Shot _____

Any Special Instructions _____

_____

In the event that emergency medical treatment is requires due to an illness or injury during the therapeutic riding session, I authorize RIDE to:

1. Call emergency medical help and consent to an necessary treatment that may include transportation, x-ray examination, surgery, medication, or hospitalization.
2. Release student records upon request of authorized emergency medical personnel of needed.

It is understood that every effort shall be made to contact undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Consent Signature _____ Date _____

Print Name and Relationship _____

Telephone numbers where parents can be reached _____

Mother _____ Father _____

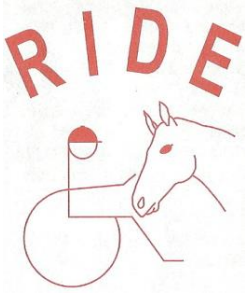


Photo Release Form

The undersigned hereby grants RIDE Therapeutic Horsemanship Program permission to take or have sill or moving photographs of myself, daughter, son . The Undersigned also authorizes RIDE to use such photographs in its advertising, news, media, brochures, pamphlets, and instructional material.

Date _____

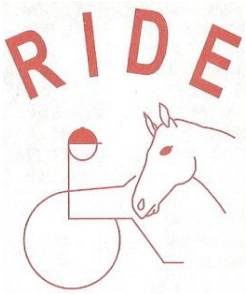
Signed _____

Reaseach Date Release Form

The undersigned hereby grants permission to use all test results and scores obtained from evaluations, both formal and informal of
While said person is in attendance at RIDE Therapeutic Horsmanship Program. Aforesaid material will be used for the purpose of research and conducted by RIDE and RIDE staff or consultants. No use of this date will be included in published material.

Date _____

Signed _____



Riders with Down Syndrome

RIDE, a member of PATH (Proffessional Association of Therapuetic Horsmanship), supports the position taken by PATH regarding the necessity for X-rays of all Down Syndrome riders.

It is recommended that all Down Syndrome riders have X-rays to determine if Alantoaxial Instability is present. AL, simply explained, is an instability or dislocation of the joints between the fist and second cervical vertebrae that could result in serious injury or paralysis.

Please ensure your child's safety by having an X-ray taken and read by a qualified physician.

By Signing below you agree that you have read and understand the precaution.

Name of Rider _____

Parent/Guardian _____

Date of Exam _____

Results of Exam _____

_____ _____

Parent/Guardian Signature Date

Seizure Information Form

Does the rider have seizures? Y N

If yes, Please fill out the following form.

What may cause the seizures?

On average, how often do they occur?

Are there any warning signs before a seizure starts?

What is the average duration of a seizure?

How Does the participant feel and behave after a seizure? How long does this last?

What should we do should a seizure occur while riding?

Is there anything else that we need to know about the seizures?