THERAPEUTIC RIDING CLIENT APPLICATION

GENERAL INFORMATION

Application Date:_____

Applicant Name: _____ Check: □ Male □ Female

Height: _____ Weight:_____ Date of Birth:___/_____/____ Age:_____

Parent/Legal Guardian: _____ Ethnicity: _____

Not required; for grant application purposes only.

Phone: _____ Email: _____

Address: _____ City:_____ State:_____ Zip:_____

Case worker: _____ Case worker #: _____

E-Mail:_____

Primary Diagnosis: _____

Referral Source: _____

Previous experience with horses or therapeutic riding? □ Yes □ No

Is the applicant a Victim of Abuse, or an At-Risk Youth? □ Yes □ No

SCHEDULING INFORMATION

SESSIONS ARE BY APPOINTMENT.
EACH LESSON LASTS 1 HR. (including grooming and tacking up) Please arrive on time.
For scheduling purposes, please circle preferred day(s):

MON TUES WED THURS FRI AM OR PM

Goals (reason for applying; what would you like to see accomplished):

_____

_____

_____

Helping with Horsepower at Reclamation-Ranch Riding Student Session Terms and Policies

1. All Equine Assisted Therapy sessions will be assigned to the instructor we feel is best suited to provide the instruction. We reserve the right to substitute instructors as we deem appropriate. If you have any questions or concerns regarding the instructor assigned to your session, please discuss them with the Ranch Manager. (Crystal Young) We also reserve the right to teach multiple students at the same time as we deem appropriate. We do not guarantee individual or private sessions.
2. We require proper clothing, (pants) close toed shoes (limited sizes available if need), and a riding helmet (provided at session if rider does not have his/her own). If the participant arrives wearing improper attire, the assigned instructor may ask for the session to be rescheduled.
3. If the rider refuses to wear a helmet, by signing this agreement, you as the parent/guardian acknowledge the risks and take full responsibility for this decision.
4. We will select the horse we deem appropriate to the student and the day's Equine Assisted Therapy sessions. this includes the right to change horses as we think best in the interest of the safety of the sessions and the day's goals for the session.
5. Most Equine Assisted Therapy Sessions will average an hour in length. However, each individual Equine Assisted Therapy session is objective based, not time based and the actual length of instruction may vary depending on the student's progress that particular day.
6. Your appointed day and time are when your Equine Assisted Therapy sessions have been scheduled for. This is the block of time you are paying for and the block of time we have set aside for your child's Equine Assisted Therapy. If you are late for the appointed time, that time may be taken out of your session. For example, if your session is at 10AM and you arrive at 10:20AM, the ending time for your session is still 11AM and your available session will be reduced accordingly.
7. No Show Policy- We will require a 3-hour notice if you are unable to make your scheduled lesson. The penalty for not giving notice will be the full lesson price and forfeit of session. We are aware that emergency situations can occur and will do our best to accommodate those cases. We will do our best to reschedule the session but it is subject to the availability.
8. Parents and family are invited and encouraged to watch sessions, but please do not participate without prior approval. Please let the instructor do their job without interference or distraction. If you have any questions or concerns, feel free to discuss them with the Ranch Manager, but please do not interrupt the instructor during a session.
9. Our primary goal is that the student be able to participate in horse activities as sagely as possible taking into consideration that such activities, horses are inherently dangerous. Next is that the enjoy the activity and finally that they learn the necessary skills to accomplish their individual and personal goals.
10. At any time there are questions or concerns, please bring them to the attention of the Ranch Manager.
11. You are responsible for session fees unless other arrangements are made in writing with the Program Director. (Crystal Young)
12. **We do encourage you to keep a journal to document and acknowledge your child's journey through Equine Assisted Therapy.**
13. **This agreement is month to month and may be canceled with 30 days notice by either party.**

Parent Name: _____ **Date:** _____

Signature: _____

Staff Witness: _____ **Print:** _____

Please return to: Helping With Horsepower™ - 40787 259th St., Mitchell, SD 57301
email: laura@helpingwithhorsepower.com (605)999-9824 or reclamationranch@gmail.com (605)770-2867

APPLICANT HEALTH HISTORY

Please indicate current/past problems in the following areas (Please include triggers, if any):

Vision: _____

Hearing: _____

Sensation: _____

Communication: _____

Heart: _____

Breathing: _____

Digestion: _____

Elimination: _____

Circulation: _____

Emotional: _____

Behavioral: _____

Pain: _____

Bone/Joint: _____

Muscular: _____

Thinking/Cognitive: _____

Allergies: _____

APPLICANT HEALTH HISTORY (continued)

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Current Medications of Applicant (over-the counter included):

_____

_____

_____

Please describe applicant's <u>FUNCTIONAL</u> abilities and difficulties, such as: mobility skills (transfers, walking, wheelchair use, driving/bus riding):

_____

_____

_____

***Please describe assistance required or equipment needed:**

_____

_____

Please describe applicant's <u>SOCIAL</u> abilities and difficulties, such as: work/school (grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.):

_____

_____

_____

***Please describe assistance required or equipment needed:**

_____

_____

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APPLICANT INFORMATION

Please tell us about the applicant. (Likes: Favorite food, hobbies, pets, home life, siblings) (Dislikes: pets, sounds, etc.):

_____

_____

_____

What types of things work best for the applicant in terms of rewards and motivation?

_____

_____

_____

How does the applicant best communicate with others?

- □ Spoken Language
- □ Written Language
- □ Sign Language □ASL □E/E
- □ Communication device
- □ Combination of the above (please describe)

_____

_____

Does the applicant use:

- □ Echolalia (repeating words without regard for meaning)
- □ Stemming (rocking, spinning, hand flapping)
- □ Self Regulatory Behavior (Please describe how the applicant uses this self soothing behavior):

_____

_____

Do changes in the applicant's environment affect their behavior?

- □ Never
- □ Sometimes
- □ Frequently

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Applicant's Name: _____ Date of Birth: ____/____/_____Phone: (___)_____

Applicant's Address: _____ City: _____ State:____ Zip Code:_____

Medical Facility:_____ Phone: (_____)_____

Physician's Name:_____ Phone: (_____)_____

Health Insurance Company:_____ Policy #:_____

Allergies to Medications:_____

_____

Current Medications: _____

Emergency Contacts:

Name: _____ Relation:_____ Phone: (____)_____

Name: _____ Relation:_____ Phone: (____)_____

Name: _____ Relation:_____ Phone: (____)_____

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 property of the agency, I authorize Helping With Horsepower™ to:

1. Secure and retain medical treatment and transportation if needed.
2. Release volunteer records upon request to the authorized individual or agency involved in the medical emergency treatment.

*(Please sign the CONSENT PLAN or the NON-CONSENT PLAN on next page)

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Consent Plan

I ***DO*** give authorization that may include x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the emergency contact person(s) above is unable to be reached.

Signature: _____ Date: ____/_____/_____

If under 18 years of age, parent/guardian signature required below.

Signature: _____ Date: ____/____/_____

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. In the event emergency treatment aid is required; I wish the following procedures to take place:

_____

_____

_____

Signature: _____ Date: _____/_____/_____

If under 18 years of age, parent/guardian signature required below.

Signature: _____ Date: ____/_____/_____

PHOTO AND VIDEO CONSENT

I, _____ consent_____ or **do not** consent_____ to authorize the use and reproduction by Helping With Horsepower™ at Reclamation-Ranch 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: _____/_____/_____

If under 18 years of age, parent/guardian signature required below.

Signature: _____ Date: ____/_____/_____

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Helping With Horsepower™ at Reclamation-Ranch

RELEASE OF LIABILITY

This Release of Liability is made and entered into on this date _____/_____/_____ and for thereafter between Laura M. Klock (President/Director) and Helping With Horsepower™ at Reclamation Ranch, and

_____

(The Participant); and, if Participant is a minor, their Parent or Legal Guardian _____.

In return for use, today and on future dates, of the property, facility and services of the Director, the Participant, his heirs, assigns and legal representatives, hereby expressly agree to the following:

1. It is the responsibility of the Participant to carry full and complete insurance coverage on his/her horse if he/she owns or leases one, personal property, and him/herself.
2. Participant agrees to assume Any And All Risks Involved In Or Arising From Participant's Use Of Or Presence Upon HWH, and the Property And Facility including without limitation the risk of death, bodily injury, property damage, all kicks, bites, collisions with vehicles, horses, or stationary objects, fire or explosion, the unavailability of emergency care, or the negligence or deliberate act of another person.
3. Participant agrees to hold HWH, the Director and all its successors, assigns, subsidiaries, franchises, affiliates, officers, directors, employees and agents completely harmless and not liable, and releases them from all liability whatsoever, and Agrees Not To Sue them on account of, or in connection with any claims, causes of action, injuries, damages, costs or expenses arising out of the Participant's use of or presence upon HWH, and the property and facility, including without limitation, those based on death, bodily injury, or property damage, including consequential damages.
4. Participant agrees to waive the protection afforded by any statute or law in any jurisdiction whose purpose, substance and/or effect is to provide that a general release shall not extend to claims, material or otherwise which the person giving the release does not know or suspect to exist at the time of executing this release.
5. Participant agrees to indemnify and defend HWH, and the Director against, and hold it harmless from any and all claims, causes of action, damages judgments, costs or expenses, including attorney's fees, which in any way arise from the Participant's use of or presence upon HWH, and the property or facility at Reclamation-Ranch.
6. Participant agrees to abide by all of HWH, and the property safety rules and regulations.
7. If Participant is using his/her horse, the horse shall be free from infection, contagious or transmittable disease. HWH, and the Director reserve the right to refuse horse if not in proper health, or is deemed dangerous or undesirable.
8. This contract is non-assignable and non-transferable, and is made and entered into in the State of South Dakota, and shall be enforced and interpreted under the laws of this State. Should any be in conflict with State law, then that clause is null and void. When HWH, the Director and Participant, or Participant's Parent or Legal Guardian if Participant is a minor, sign this contract, it will then be binding on both parties, subject to the above terms and conditions.
9. Warning: Under South Dakota law, an Equine Professional is not liable for an injury to and/or the death of a participant in equine activities resulting from the inherent risks of equine activities.

Signature: _____ Date:____/_____/_____

If under 18 years of age, parent/guardian signature required below.

Signature:_____ Date:____/_____/_____

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PHYSICIAN'S PRESCRIPTION

(To be filled out by physician only)

Dear Physician:

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 therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

ORTHOPEDIC

Atlantoaxial Instability - include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossifications
Joint Subluxation Dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion / Fixation
Spinal Instability /Abnormalities

NEUROLOGIC

Hydrocephalus / Shunt
Seizure
Spina Bifida / Chiari II malformation/Tethered Cord
Hydromyelia

OTHER

Indwelling Catheters
Medications - i.e. photosensitivity
Skin Breakdown

MEDICAL/PSYCHOLOGICAL

Allergies
Animal Abuse
Physical/Sexual Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorder
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the operating center at the address and phone indicated below. Sincerely,

Physician's Prescription

Client's Name: _____ Phone: (_____) _____

Prescription for Therapeutic Horseback Riding

Prescription, where appropriate for evaluation and treatment by a Physical, Occupational and/or Speech Therapist in conjunction with Helping With Horsepower.

Recommended Frequency:

Precautions:

Physician's Signature: _____ Date: ____/_____/_____

Return To:

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MEDICAL HISTORY & PHYSICIAN'S STATEMENT

(To be filled out by physician only)

Applicant Name:_____ Male□ Female □ Date of Birth:___/_____/_____

Height:_____ Weight:_____ Diagnosis:_____

Date of Onset: ____/_____/_____ Past/Prospective Surgeries:_____

Medications: _____

Seizure Type: _____ Controlled: □ Yes □ No Date of Last Seizure: ____/_____/_____

Shunt Present: □ Yes □ No Date of Last Revision: ____/_____/_____

Special Precautions/Needs: _____

Mobility:

Independent Ambulation: □ Yes □ No Assisted Ambulation: □ Yes □ No

Braces/Assistive Devices: _____ Wheelchair: □ Yes □ No

For Those With Down Syndrome AtlantoDens Interval X-Rays, Date: ____/_____/_____ Results: + or -

Neurologic Symptoms of AtlantoAxial Instability:_____

PLEASE INDICATE CURRENT/PAST DIFFICULTIES IN SYSTEMS/AREAS; INCLUDE SURGERIES:

Auditory:_____

Visual: _____

Tactile Sensation: _____

Speech: _____

Cardiac: _____

Circulatory: _____

Integumentary/Skin: _____

Immunity: _____

Pulmonary: _____

Neurologic: _____

Muscular: _____

Balance: _____

Orthopedic: _____

Allergies: _____

Learning Disability: _____

Cognitive: _____

Emotional: _____

Pain: _____

Other: _____

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above, against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (eg. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name/Title:_____ License/UPIN #:_____

Signature:_____ Date:_____/_____/_____

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PHYSICAL/OCCUPATIONAL THERAPY QUESTIONNAIRE

(To be filled out by therapist only)

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

Address: _____

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

The above named client has applied for Therapeutic Horseback Riding Sessions at Helping With Horsepower™ at Reclamation-Ranch. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input. It is our intent to use our program as an extension of the services you provide; therefore, the following information is very helpful to us. We want to assimilate your goals (both short term and long term) into ours for this person.

Specific Physical Therapy Needs to Address:

Current Treatment Goals: (we set 8-10 goals and evaluate progress every 12 weeks)

Recommended Gross Motor Activities:

Any Helpful Hints for Working with This Person:

_____
Print Name

_____ _____/_____/_____
Physical/Occupational Therapist (Please Sign) **Date**

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SPECIAL EDUCATION TEACHER QUESTIONNAIRE

(To be filled out by special education teacher only)

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

Address: _____

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

The above named client has applied for Therapeutic Horseback Riding Sessions at Helping With Horsepower™ at Reclamation-Ranch. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input. It is our intent to use our program as an extension of the services you provide; therefore, the following information is very helpful to us. We want to assimilate your goals (both short term and long term) into ours for this person.

Specific Cognitive and/or Behavioral Needs to Address:

Current Treatment Goals: (we set 8-10 goals and evaluate progress every 12 weeks)

Recommended Activities:

Any Helpful Hints for Working with This Person:

_____ _____/_____/_____

Special Education Teacher (Please Sign) **Date**

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BEHAVIORAL THERAPY QUESTIONNAIRE

(To be filled out by therapist only)

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

Address: _____

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

The above named client has applied for Therapeutic Horseback Riding Sessions at Helping With Horsepower™ at Reclamation-Ranch. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input. It is our intent to use our program as an extension of the services you provide; therefore, the following information is very helpful to us. We want to assimilate your goals (both short term and long term) into ours for this person.

Specific Behavioral Therapy Needs to Address:

Current Treatment Goals: (we set 8-10 goals and evaluate progress every 12 weeks)

Recommended Activities:

Any Helpful Hints for Working with This Person:

_____ _____/_____/_____

Behavioral Therapist (Please Sign) **Date**

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SPEECH THERAPY QUESTIONNAIRE

(To be filled out by therapist only)

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

Address: _____

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

The above named client has applied for Therapeutic Horseback Riding Sessions at Helping With Horsepower™. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input. It is our intent to use our program as an extension of the services you provide; therefore, the following information is very helpful to us. We want to assimilate your goals (both short term and long term) into ours for this person.

Specific Speech Therapy Needs to Address:

Current Treatment Goals: (we set 8-10 goals and evaluate progress every 12 weeks)

Recommended Oral Motor Activities:

Any Helpful Hints for Working with This Person:

_____ _____/_____/_____

Speech Therapist (Please Sign) **Date**

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