

*Equilibrium Therapeutic Riding
Rider Application Form*

A) Physician Referral Form

Name: _____ Date of Birth: _____

Address: _____

Phone (Home): _____ (Work) _____

Next of Kin/ Guardian: _____

Living at home: _____ Other: _____

Medical:

Primary Diagnosis: _____

Secondary Diagnosis: _____

Height: _____ Weight: _____ Sex: _____

Diabetic: _____ Insulin: _____ Epileptic: _____

If Epileptic, frequency of seizures: _____ Date of last seizure: _____

Scoliosis: _____ Degree of Scoliosis: _____

Medications: _____

For: _____

Communicable disease?: YES NO If yes, explain: _____

Surgery: _____ Dates: _____

Ambulatory: YES _____ NO _____

Muscle Tone (Spasticity, flaccidity etc.)

Tone in upper extremities: _____

Tone in lower extremities: _____

(Please Complete Both pages of form)

Tone in Trunk: _____

Balance sitting: _____ Standing: _____ Walking: _____

Language: English: _____ Sign Language: _____ Other: _____

Speech: Good: _____ Fair: _____ Poor: _____

Sensory Function: Sight: _____ Hearing: _____ Tactile: _____

Continence: _____

Allergies: _____

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I hereby give my permission for the above individual to participate in the riding program at *Equilibrium Therapeutic Riding*.

Physicians Signature: _____

Physician's Name: _____

Physician's address: _____

Telephone: _____

This form is good for (physician please check one):

- _____ 1 year
- _____ 2 years
- _____ 5 years
- _____ Life

Note: It is important that this form be filled out in detail (e.g. height and weight, etc.) in order for the instructor and other professionals involved to match the rider with the mount.

Equilibrium Therapeutic Riding

B) Registration

Client: _____ **Date of Birth:** _____

Age: _____ **Height:** _____ **Weight:** _____

Address: _____ **City:** _____

Province: _____ **Postal Code:** _____

Email address: _____

Phone: (Home) _____ **Work:** _____ **Emergency:** _____

Parents or Guardian: _____

Address: _____ **City:** _____

Province: _____ **Postal Code:** _____ **Phone:** _____

In case of emergency, contact: _____ **Phone:** _____

Or: _____ **Phone:** _____

Sask Health #: _____

C) Liability Release

_____ would like to participate in the *Equilibrium Therapeutic*

(*Client's Name*)

Riding program. I acknowledge the risks and potential for risk, of horseback riding. However, I feel that 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 against *Equilibrium Therapeutic Riding*, its owner, Instructors, Therapists, Aides and employees for any and all injuries and/or losses

I/my son/my daughter/my ward may sustain while participating in *Equilibrium Therapeutic Riding*.

Date:_____ Signature:_____
(Rider over 18 yrs, parent or guardian)

Witness:_____

D)Photo Release

I hereby consent to and authorize the use and reproduction by *Equilibrium Therapeutic Riding* of any and all photographs and/or any other audiovisual materials taken of me/my son/my daughter/my ward, for promotional material, educational activities, exhibitions, or for any other use for the benefit of the program.

Date:_____ Signature:_____
(Rider over 18yrs, parent, guardian)

E) Consent for Release of Information

I herby authorize _____ to release information from the records
(Person or facility)

Of _____. The information is to be released to *Equilibrium*
(Rider's Name)

***Therapeutic Riding* for the purpose of developing a Therapeutic Riding Program for the above-named client. The information to be released is marked below.**

YES

_____ **Medical History**

_____ **Physiotherapy evaluation, assessment and program plan.**

_____ **Occupational therapy evaluation, assessment and program plan.**

_____ **Speech therapy evaluation, assessment and program plan.**

_____ **Classroom Individualized Education Plan (I.E.P)**

_____ Other

Date: _____ Signature: _____
(Client over 18 yrs, parent or guardian.)

Please send the indicated material to:

Equilibrium Therapeutic Riding c/o Erin McCormick Box 517
Osler, SK S0K 3A0

F) Information Release Form

I hereby authorize *Equilibrium Therapeutic Riding* to release to its instructors and staff, such information as may be necessary to a beneficial and safe riding program.

Name of Rider: _____

Date: _____

Signed: _____

Relation to rider: _____

Witness: _____

***Equilibrium Therapeutic Riding
Program Requirements and Regulations***

- *Equilibrium Therapeutic Riding* offers consistent, individualized and holistic programming. In order to best serve individuals with disabilities weekly riding lessons are offered. It is understandable that success with any program and with any individual, takes time. In order to give each rider the opportunity to be successful, riding lessons are set up in blocks, with one lesson per week and four lessons per month. The current five month block begins September 1st, 2009 and runs until January 31st, 2009.
- Should the rider fall ill or need to cancel a weekly lesson, 24 hours notice will be required, in order for the lesson to be re-scheduled at a separate time. If 24 hours notice is not given, the lesson will not be re-scheduled and the lesson fee will be forfeited to *Equilibrium Therapeutic Riding*. Should *Equilibrium Therapeutic Riding* cancel a lesson, as much notice as possible will be given and the lesson will be made up at a separate time.
- Post-dated cheques and fully completed doctors note and application will be Required prior to the student's first ride. Post dated cheques, dated for the first of every month, should be made payable to *Equilibrium Therapeutic Riding*.
- Each student is entitled to an introductory assessment. During this assessment, *Equilibrium Therapeutic Riding*, will determine whether or not therapeutic riding interests the individual. Should the rider wish to enroll, a Individualized Program Plan will be formulated, with the assistance of the individual and others involved in the student's life.(ie. Parents, guardians, support-workers, teachers and aids, occupational and/or physical therapists etc.) Once an adequate program and attainable goals have been set, the individual will begin riding lessons.
- Each student is required to wear appropriate head gear at all times. This means a riding helmet. A boot with a small heel is required as well. Although the arena is insulated, it is recommended that students dress in layers during the winter, which can be removed should he/she get warmer during the lesson.(Suggestion: Long Johns) Gloves or mittens and a warm hat must be worn during the winter. It is necessary that students wear long pants during summer as well, to prevent skin chaffing against the saddle.

- A schedule is available at the stables to determine the number of lessons there are each month. Some lessons may fall on long weekends and holidays, so consult with your schedule to determine this in advance. Let me know what your plans are ahead of time for holidays and I'll accommodate or reduce your monthly payment.

Equilibrium Therapeutic Riding
Atlanto-Axial X-ray verification for Riders with Down Syndrome

Rider Name: _____ **Date of Birth:** _____

Address: _____

Telephone: _____

Height: _____ **Weight:** _____

Name of Physician: _____

Telephone: _____

Date of X-ray: _____

Physician's Signature: _____

Note: Due to the nature of this activity, persons diagnosed with Down Syndrome cannot be accepted for riding instruction without proof of a negative diagnostic X-ray for atlanto-axial instability. This form must be accompanied by a signed and dated statement from a qualified physician, giving the date and the result of the diagnostic X-ray.