The New Mexico Center for Therapeutic Riding

Rider Application 2017

Rider Packet Checklist

All of the forms listed below are required to be completed, checked, signed and dated as indicated prior to the start of rider participation and annually thereafter.

To be completed by rider, parent or caregiver:

☐ 1.Therapeutic Riding Application and Release

☐ 2. Photo Release

☐ 3. Consent Plan

☐ 4. Authorization for Emergency Medical Treatment Form

☐ 5. Insurance Waiver and Release Liability

☐ 6. Rider Goal Sheet

☐ 7. Scheduling Request Form

To be completed by the rider's Physician and Therapist:

☐ 8. Physician's Letter and Physician's Release

☐ 9. Therapist Assessment (Speech, PT, OT)

For Official Use Only:

Forms	1	2	3	4	5	6	7	8	9

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The New Mexico Center for Therapeutic Riding

Rider Application 2017

Participant Name: _____
(Last) (First)

Address: _____

Date of Birth: _____ Height: _____ Weight: _____

Parent / Legal Guardian: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____

Disability: _____ Date of Onset: _____

Educational Placement: _____ School: _____

Employer:	Business Phone & Hours:
Parent's name & employer:	Business Phone & Hours:
2nd Parent's name & employer:	Business Phone & Hours:

Physician Name: _____

Address: _____

Office Phone: _____

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Application Release

No participant can be accepted for participations until the Parent/Guardian has completed this form. If the participant is of legal age and mentally competent, he/she may complete the form without parent's supervision. Every effort will be made to avoid any accident, however, NO LIABILITY can be accepted by any of the organization's trustees, agents, employees, each and every one of its member and associates, the property owners upon whose land the lessons are conducted.

I would like _____ to participate at NMCTR. I have discussed this with the doctor. Furthermore, I grant permission to a NMCTR instructor or therapist to contact my doctor or therapist for further clarification of medical information if needed (this information will be treated with confidentiality). I understand that NO LIABILITY can be accepted by any of the organizations concerned with this instruction or therapy, including The New Mexico Center for Therapeutic Riding (NMCTR).

I understand that the final decision regarding acceptance, selected therapeutic activities, and continued participation rests with the NMCTR staff, upon due consideration of the individual's special needs and the safety of the participant, staff, volunteers and horses.

SIGNITURE OF RIDER OF LEGAL AGE: _____
DATE: _____

SIGNATURE OF PARENT(S)/ GUARDIAN: _____
DATE: _____

Photo/Video Release

I hereby grant the New Mexico Center for Therapeutic Riding permission to use any and all photographs, slides, and any other audiovisual materials in which I may appear for the express purpose of promoting the NMCTR programs and do not expect, nor shall receive any monetary reimbursement for this authorization.
_____ (CONSENT initials) _____ (NON-CONSENT initials)

Signature _____ Date _____

IF MINOR, Signature of Parent/Guardian _____

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Consent Plan

In the event of an emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the NMCTR premises, I authorize NMCTR to:

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

Initials: _____

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached. Emergency services from this area utilize Christus St. Vincent's Medical Hospital.
Other preference: _____

Date: _____

SIGNATURE _____
(Signature of Parent/ Legal Guardian, or legally competent adult rider over 21)

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 on the NMCTR premises.

- Parent or legal guardian will remain on site at all times during equine assisted activities.
- In the event of emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

_____

Date: _____

SIGNATURE _____
(Signature of Parent/ Legal Guardian, or legally competent adult rider over 21)

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Authorization for Emergency Medical Treatment Form

Name: _____ Date of Birth: _____

Height: _____ Weight: _____

Medical Information:

Physician: _____

Address: _____ Hospital: _____

Medical Insurance Company: _____

Address: _____

Policy Number: _____ Group Number: _____

Company or Agent Phone: _____

MEDICAL HISTORY

Medications: _____

Allergies: (medications, insect bites, etc.) _____

IN CASE OF EMERGENCY:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

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Insurance Waiver and Release of Liability

RIDER'S NAME (please print): _____

In consideration of being allowed to participate in any way in The New Mexico Center for Therapeutic Riding Program, I and/or the minor participant, the Undersigned:

1. Agree that prior to participating, I will inspect, or if a parent and/or guardian, I will instruct the minor to inspect the facilities and equipment to be used, and if I believe to the best of my ability that anything is unsafe, I and/or the minor participant will immediately advise the NMCTR of such condition(s) and refuse to participate.
2. Acknowledge and fully understand that I, and/or the minor participant, will be engaging in equine-related activities both mounted and non-mounted that involve risk of serious injury, including permanent disability and death, and severe social and emotional losses which might result only from my own actions, inactions or negligence of others, the rules of play, or the conditions of the premises or any equipment used. Further, that there may be other risks not known to me or not reasonable foreseeable at this time.
3. Assume all foregoing risks and accept personal responsibility for the damages following such injury, permanent disability or death.
4. Release, waive, discharge and covenant not to sue the New Mexico Center for Therapeutic Riding, their representative administrators, directors, paid and volunteer staff, independent contractors, sponsoring agencies, sponsors, advertisers, their heirs, and if applicable, owner and leasers of premises used to conduct the New Mexico Center for Therapeutic Riding, all of which hereinafter referred to release from demands, losses or damages to property, caused or alleged to be caused in whole or part by negligence of the releases or otherwise.

_____

Rider's Name Signature Date

_____

Address City/State, Zip

_____

Home Phone Cell Phone Work Phone Email

_____

Parent/Guardian's Name Signature Date

_____

2nd Parent/Guardian's Name Signature Date

_____

Parent/Guardian Home Phone Cell Phone Work Phone Email

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Rider 2016 Goals

Goals:

Please help us help you get the most out of your classes by filling out the following goal setting sheet. Please hand back to your instructor at the next class. Thank you.

Rider name: _____

All goals are reflective of the **next term**. The categories are meant as a guideline and may not apply to all students.

Personal riding goals:

_____

_____

Physical goals:

_____

_____

Cognitive goals:

_____

_____

Social goals:

_____

_____

Long-term goal:

_____

_____

Goals Dated: _____

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Scheduling Request Form

Rider's Name:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Availability:

1) Please indicate **days/times** you are available for a lesson.
2) No guarantee on ride times. Lessons are coordinated to rider level.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning (8a-11a)							
Afternoon (12p-3p)							
Evening (4p-6p)							

Please check one: **GROUP: _____** **PRIVATE: _____**

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Physician's Letter

Date: Riding Season 2017

Dear Health Care Provider:

Your patient, _____ is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. 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.

Orthopedic

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

Neurologic

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

Other

Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

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

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center.

Sincerely,

Ashley Armijo
505-948-6900

The New Mexico Center for Therapeutic Riding

Rider Application 2017

NMCTR Medical History/Physician's Release

Name: _____ Date of Birth: _____ Age: _____

Address: _____

Name of Parent(s)/Guardian: _____

Diagnosis: _____ Date of Onset: _____

Tetanus Shot: □ Yes □ No Date of Shot: _____

Height: _____ Weight: _____

Seizures: Type: _____ Controlled? _____ Date of Last Seizure: _____

Medications: _____

Areas	Normal	Problems/Deficits	Comments/Surgeries
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Orthopedic			
Scoliosis			
Type/Degree			
Allergies			
Learning Disability			
Mental Impairment			
Psych. Impairment			
Shunt	Yes:	No:	
GI Tubes	Yes:	No:	
Catheter	Yes:	No:	
Other			

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Mobility:

Independent Ambulation:	☐ Yes	☐ No
Braces:	☐ Yes	☐ No
Crutches:	☐ Yes	☐ No
Wheelchair:	☐ Yes	☐ No

OTHER SPECIAL PRECAUTIONS: _____

_____

I have reviewed the **CONTRAINDICATIONS** on this form. In my opinion this patient has none of these contraindications and may participate in supervised equestrian activities. In conjunction with these activities, I concur in the referral of the participant to a PT/OT/ or SLP or other health care professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian or therapy program. I understand that the final decision regarding acceptance rests with the NMCTR staff, volunteers and horses.
This form MUST BE signed and stamped by a physician.

Physician's Name (please print) _____

Physician's Signature _____ Date _____

Address _____ Phone _____

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PHYSICAL, OCCUPATIONAL, OR SPEECH/LANGUAGE THERAPY EVALUATION

To be completed by participant's primary therapist (PT, OT, or SLP).

*If applicant is not receiving PT/OT/or SLP services at this time, please sign here to indicate that this form does not apply: _____

Signature

Name: _____ Date of Birth: _____
Disability: _____
Therapist: _____ Phone: _____

Muscle Tone: _____

_____

Balance/Coordination: _____

_____

Mobility/ Assisted Devices: _____

_____

Associated Reactions/Abnormal Reactions: _____

_____

Comprehension of Verbal Instruction: _____

_____

Psycho-Social/Behavioral: _____

_____

Other Special Precautions: _____

_____

Present Goals of PT / OT / SLP Program: _____

_____

SIGNATURE: _____ DATE: _____

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