



Horses Help Therapeutic Riding Center

PO Box 71005, Phoenix, Arizona 85050 www.horseshelp.org Office: 602-569-6056

Freedom Riders Welcome Information

PAPERWORK

All forms should be completed and signed prior to the first session. All participants including our returning clients must complete new paperwork each year including the doctor's release for equestrian activities.

SCHEDULING

General: Scheduling is on a first come first serve basis. We group participants together by skill level, age, and availability. We will ask for three time preferences when scheduling. Riders participate one time per week for each four week session.

New Participants: When a new participant returns the application for Wounded Warrior therapeutic riding you will be scheduled for telephone orientation and transportation coordination to and from Horses Help for your class. There will be an orientation tour at the beginning of your first class and you will be fitted for a horseback riding helmet. Then one of our certified riding instructors will do an intake evaluation. It is important to arrive on time for the first class.

Returning Participants: You will be placed according to skill level after paperwork is complete. Class times are on a first come first serve basis so it is very important to return paperwork promptly.

CANCELLATIONS

Weather is unpredictable in Arizona, so Horses Help reserves the right to cancel any classes when it deems unsafe conditions exist to ride. This will ensure the safety of its riders, staff, volunteers and horses.

Initials _____

LATE ARRIVALS

Please let us know if you are going to be late. Classes are planned and prepared for, our staff, volunteers and horses are dedicated to you, so if you're late, communicate! You are due to arrive 15 minutes before the scheduled ride time. We will wait for 15 minutes past the scheduled ride time if you have called ahead. Class will continue without you, or, if the horse is not working with another classmate, be put away after this 15 minute period and will not be available so we do not disrupt the current active class.

Initials _____

PAYMENT PROCEDURES

Freedom Rider's Therapeutic Riding is a 1 Hour Semi-Private Class
All Freedom Riders Participants participate at no cost to the rider

Initials _____

OBSERVING CLASSES

We are happy to have families and friends of participants observe, as long as it does not distract the class. In order to keep the integrity of the class, we ask that you do not interrupt or distract the participant during the active session. There are specific areas designated for observation. Please control the activities of children to avoid injury. Many family members or friends wish to help by side walking during class. We are happy to train you for this skill. However, it will be unlikely that you will be working directly with your veteran. Let us know if you wish to participate.

Initials _____

HORSES

Do not feed any of the horses. Our animals are on special diets and you may interfere with their health. In addition, unsupervised feeding of animals may result in injury. **Please do not go into the barn area** without an instructor or designated volunteer.

Initials _____

PETS

We have a high commitment to safety for our clients and horses, therefore, no pets are allowed on the premises. Exceptions are certified companion or working therapy support animals.

Initials _____

PARKING/DRIVING

Please park in the designated areas. Do not block gate access areas. If there is no parking available please ask a staff member for direction. Please observe the 5 MPH sign while on the property; we do have horses and riders up and moving from one arena to another. Your cooperation is appreciated.

SMOKING: PARTICIPANTS AND GUESTS

There is absolutely no smoking on site.

I understand the information in this form and agree to the following conditions as defined by Horses Help organization.

Signature _____

Date _____

HORSES HELP – RIDER APPLICATION Ride Year

(MUST be filled in completely in **Blue** or **Black Ink ONLY**)

NAME: _____ DATE COMPLETED: _____

ADDRESS: _____ HOME PHONE: (____) _____

CITY/STATE: _____ ZIP: _____ ALT. PHONE: (____) _____

BIRTH DATE: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____

Male/Female _____

DISABILITY (primary & secondary): _____

SEIZURES: YES NO CONTROLLED DATE OF LAST SEIZURE: _____

MEDICATIONS: _____

AMBULATION (Wheelchair, canes, etc.): _____

PARENT/GUARDIAN: _____ E-Mail: _____

OCCUPATION/PLACE OF EMPLOYMENT: _____

SIBLINGS (NAME & AGE): _____

DOCTOR'S NAMES/ADDRESSES/PHONE: _____

THERAPIST'S NAMES/ADDRESSES/PHONE: _____

Would you provide a copy of any current therapy reports to Horses Help? YES
NO

Is your therapist willing to interact with Horses Help? YES NO

SCHOOL/EDUCATION/DAY PROGRAM: _____

PHYSICAL LIMITATIONS _____

POSITIVE REINFORCERS: _____

ATTENTION SPAN: _____ SITTING POSTURE: _____

VISUAL: _____ HEARING: _____

SPEECH: _____ PROSTHESIS: _____

Please answer the following questions (use the back if needed):

1. Have there been any significant changes in the rider's condition within the past 3 to 6 months? Please let us know of any changes in health or physical development.
2. How did you hear about Horses Help?
3. Is there anything that we should know about the rider?
4. What are your expectations of Horses Help?



HORSES HELP -- AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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 HORSES HELP 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 emergency treatment.

Rider Name: _____

Address: _____ City: _____ Zip Code: _____

Telephone: (_____) _____ Date of Birth: _____

Parent/Guardian/Emergency Contact Person:

1. Name: _____ Phone: (_____) _____

2. Name: _____ Phone: (_____) _____

Physician's Name: _____

Preferred Medical Facility: _____

Health Insurance Company: _____ Insurance ID _____

ALLERGIES, MEDICAL CONDITIONS and MEDICATIONS (Please list any medical problems, special situations, seizure activity, etc.)

CONSENT PLAN

This authorization includes X-ray, surgery, hospitalization, medical and any treatment deemed "Life Saving" by the physician. This provision will only be invoked if the person listed below is unable to be reached.

Date: _____ Consent Signature: _____
(Parent or Guardian must sign if rider or volunteer is under age of 18)

PRINT Contact Name: _____ Phone: _____

Address: _____

NON-CONSENT PLAN

I do not give my consent to 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.

Date: _____ Non-Consent Signature: _____

(Parent or Guardian must sign if rider or volunteer is under age of 18)

PRINT Name: _____ Phone: (_____) _____

Address: _____

HORSES HELP PHOTO RELEASE

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

Signature of Rider,

Parent or Guardian (if rider is under age of 18)

Date

WARNING: Under Arizona Law, an equine activity sponsor or equine professional is not liable for any injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to A.R.S. s12-553

RISK MANAGEMENT / CONFIDENTIALITY STATEMENTS

- | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|---|
| ❖ I understand that I cannot smoke while on the property of Horses Help unless in designated area. | Y | N |
| ❖ I understand Horses Help has designated business hours at which time staff will be present on property. | Y | N |
| ❖ I understand that I must wear an approved ASTM approved riding helmet to ride any horse. | Y | N |
| ❖ I understand that horses are not to be fed anything by hand. Hand feeding encourages biting and nipping. | Y | N |
| ❖ I understand that horses are unpredictable. They may kick, bite, and step on me. | Y | N |
| ❖ Volunteers, riders and their families have a right to privacy that gives them control over the dissemination of their medical and/or other sensitive information. Horses Help shall preserve that right of confidentiality for all individuals in its program. | | |

I, by signing below, acknowledge the above statements and will abide by them.

Signature of Rider and/or Parent/Guardian

Date



Dear Physician:

Your patient would like to participate in our therapeutic riding program at Horses Help. These activities are supervised by riding instructors who are certified by North American Riding for the Handicapped Association (NARHA) and assisted by volunteers. Because safety is of the utmost importance, we request your evaluation of this person's appropriateness for horseback riding at Horses Help.

We welcome your comments, questions and concerns. All of our riders must have an **original signed and dated** medical release on file with Horses Help in order to participate (see reverse side for form).

The following are some of the precautions/contraindications that we take into account when considering riders for our programs.

ORTHOPEDIC

Atlantoaxial instability – include neurologic symptoms
Coxa arthrosis
Cranial deficits
Heterotopic ossification/Myositis ossificans
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

Age – under 4 years
Indwelling catheters
Medications – i.e. photosensitivity
Poor endurance
Skin breakdown

MEDICAL/PSYCHOLOGICAL

Allergies
Animal abuse
Physical/sexual/emotional abuse
Blood pressure control
Dangerous to self or others
Exacerbation of medical conditions
Fire setting
Heart conditions
Hemophilia
Medical instability
Migraines
PVD
Respiratory compromise
Recent surgeries
Substance abuse
Thought control disorders
Weight control disorder

We appreciate your assistance. Please complete and return this form to:

**HORSES HELP: P.O. BOX 71005 · PHOENIX, AZ 85050
(602) 569-6056/ Fax 602-765-7031**

HORSES HELP MEDICAL HISTORY/PHYSICIAN RELEASE

NAME: _____ BIRTH DATE: _____ Male/Female ____
 ADDRESS: _____ CITY: _____ ZIP: _____
 PARENT/GUARDIAN: _____
 DIAGNOSIS: _____ DATE OF ONSET: _____
 TETANUS SHOT: NO YES → DATE: _____ HEIGHT: _____ WEIGHT: _____
 SEIZURES: TYPE: _____ CONTROLLED: YES NO DATE OF LAST SEIZURE: _____
 MEDICATIONS: _____

Persons with Downs Syndrome: This section must be completed in order to participate.
 Cervical X-ray for Atlanto Axial Instability: Positive: _____ Negative: _____ X-ray Date: _____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking YES or NO.
 If YES, please comment.

AREAS	YES	NO	COMMENTS
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic - Skeletal -- <i>Scoliosis Degree</i>			
Balance			
Shunts			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

MOBILITY:

Independent Ambulation: YES NO Braces: YES NO
 Crutches: YES NO Wheelchair: YES NO

Please indicate any special precautions: _____

In my opinion this patient can participate in supervised equestrian activities. In conjunction with these activities I concur in the referral of the patient to a physical/occupational therapist or other health care professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program. Valid for one year. Original Signature only.

Physician's Name (PLEASE PRINT): _____

Physician's Signature: _____

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

Phone: (_____) _____ Date: _____