RIDER AGREEMENT & REGISTRATION PACKAGE

P.O. Box 1820 205-7th Ave. N. Creston BC, V0B 1G0 ph. 250-428-2296 fax 428-2297

Welcome to CDSCL's Therapeutic Riding Program! We look forward to a wonderful relationship.

This package is designed to guide you through the registration process. Unfortunately, this process involves a lot of forms! Please understand that this paperwork is necessary for the CDSCL Therapeutic Riding Program to be in compliance with insurance requirements. It is also necessary to help the team tailor the lessons to your needs by providing the right combination of horse, equipment, tack, volunteers and lesson content.

Riders cannot participate in any activity at the CDSCL Therapeutic Riding Program without the appropriate forms. We ask that you return all forms as soon as possible – and at least one week prior to the start of lessons to allow the Instructor time to review them and set up an individualized riding program.

Prior to the first session the following forms may be required:

- Intake/Referral for Services (where applicable)
- Rider Application/Profile Form (mandatory)
- Atlanto-axial X-Ray Verification for riders with Down Syndrome (where required)
- Consent for release of information (where applicable and/or as required)
- Physician Referral Form (mandatory)
- Liability Waiver (mandatory)
- Photograph/Video Release/Non Consent Form (mandatory)
- Authorization/Non Authorization for Emergency Medical Treatment (mandatory)
- Emergency Profile (mandatory)

The following form will be required on an annual basis:

- Physician Referral Form

The following will be required prior to each session:

- Session Registration Form

If the rider's condition/situation changes at any time, please let the Program Director know and have the appropriate information updated, or the required form re-submitted.

All forms must be properly filled out, signed and returned to CDSCL before the student may ride.

Prior to a rider's acceptance to the program, there will be an assessment visit with the Instructor and other therapists as required (i.e. Physical Therapist, Occupational Therapist, Counselor etc.). An orientation visit may be arranged to fit tack, hat and belt; and to familiarize the rider with the program. These 2 visits may be combined.

For the safety of the student, volunteers and horses, some applicants may not be accepted into the program.

FEES & PAYMENT POLICIES

- Costs:
  - Annual Fee $ 20
  - Six Week Session $ 90
  - Eight Week Session $ 120
- Sessions must be prepaid in full prior to the start of the session.
- In the event of cancellation of a lesson by CDSCL, the lesson will be rescheduled.
- If lessons are proceeding as scheduled and the student does not attend, there will be no make-up lesson.

RIDER/CAREGIVER RESPONSIBILITIES:

- As we don't want to have volunteers with nothing to do and horses tacked up and ready with no rider, CDSCL must be notified if a rider will not be attending.
- A caregiver must remain on-site during the lesson unless arranged with CDSCL.
- It is the responsibility of the caregiver to have the student appropriately attired for riding and weather conditions. Boots or shoes with heels and long pants are mandatory. Riders will not be able to participate without the appropriate attire. Pant pockets should be empty of items that might poke the rider during the mount and dismount.

SESSIONS

Therapeutic Riding lessons will be taught by an Equine Canada Certified Instructor. If necessary (and available), a physical therapist will be utilized during the session. The Instructor will have access to the advice of a number of different types of therapists.

Lessons will have a maximum group of 4 riders, one hour semi private (2 riders in the ring at a time), or half hour private (1 rider in the ring).

The minimum age for participation in CDSCL's Therapeutic Riding Program at this time is 5 years.

Classes will be filled on the basis of disability needs, riding ability, volunteer ability and availability as well as horse availability. Please encourage people who are interested in volunteering to contact the Program Director. Lack of volunteers is often the only impediment to proceeding with a class. There is a great need for committed volunteers!!

Admission & Discharge Policy

It is the decision of the Program Director/Instructor/Medical Committee to admit or discharge a rider. Riders can be refused entry or discharge from the program for a variety of reasons including but not restricted to exceeding the weight allowed, failure to appear for classes, inappropriate behavior, or implications that the continuation of therapeutic riding is a contraindication.

While every effort will be made to meet a rider's needs, a rider possessing the ability and desire to advance to a higher level of instruction than the CDSCL Therapeutic Riding Program offers, will be discharged and given assistance in locating a program and/or instructor that meets their needs.

Dress

It is mandatory that all riders, volunteers and staff ride with (ASTM-SEI) helmets.

It is mandatory that hard sole shoes or boots with heels, or safety stirrups be used by all riders, volunteers and staff while riding. Stirrups and footwear must be approved by the Instructor before mounting.

Agreement

I hereby certify that I have read and agree to the above conditions.

Signature of Rider: ______________________________________ Date: ___________________

Signature of Legal Guardian: ______________________________ Date: ___________________

Signature of Witness: ____________________________________ Date: ___________________

RIDER APPLICATION FORM – TO BE FILLED OUT PRIOR TO FIRST SESSION

P.O. Box 1820 205-7th Ave. N. Creston BC, V0B 1G0 ph. 250- 428-2296 fax 428-2297

General Information:

Name: ___________________________________ Date: ___________________________

DOB: _______________ Height: ________________ Weight: _____________________

Address: ____

Home Phone: ________________________________ email: ___________________________

Employer/School: ____

Work Phone: ________________________________ Cell Phone: ______________________

Mother's Name ______________________________ Work Phone: ______________________

Address if different than above: ____

Home Phone: ___________________________ Cell Phone: ______________________

Father's Name: ______________________________ Work Phone: _____________________

Address if different than above: ____

Home Phone: ____________________________Cell Phone: ______________________

Legal Guardian Name: _________________________ Work Phone: ______________________

Address: ____

Home Phone: ___________________________ Cell Phone: ______________________

Emergency Contact Name: ______________________Relationship: ______________________

Home Phone: _______________ Work Phone: _______________ Cell Phone: _______________

How did you hear about the CDSCL Therapeutic Riding Program? ___________________________

Rider Profile

Rider has ridden before YES NO With a Therapeutic Riding Program YES NO

How long ago? ____________________________ How long? ____________________________

Is the rider ambulatory? YES NO Verbal? YES NO

If non-verbal, what form of communication does he/she use? ______________________________

Does the rider use any of the following?

Wheelchair YES NO Crutches YES NO Braces YES NO

Walker YES NO Cane YES NO

Is rider able to sit independently? YES NO

What medications are you currently taking, including over-the-counter medications?

Describe your abilities/difficulties in the following areas (include whether assistance is required or if equipment is needed):

FUNCTION (i.e. mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

SOCIAL (i.e. work/school including grade completed, leisure interests, relationships, family structure support systems, companion animals, fears/concerns etc.)

GOALS (i.e. why are you applying for participation? What would you like to accomplish?)

Are there any other therapists that are involved with the rider's care that should be part of the Therapeutic Riding team? (i.e. physical therapist, occupational therapist, counselor, chiropractor etc.)

Is there any other information that you feel CDSCL should know?

Signature of Rider: ______________________ Date: ______________

Signature of Legal Guardian: ______________________ Date: ______________

Witness: ______________________

PHYSICIAN'S REFERRAL – TO BE COMPLETED ANNUALLY BY PHYSICIAN

P.O. Box 1820 205-7th Ave. N. Creston BC, V0B 1G0 ph. 250-428-2296 fax 428-2297

Name: ______________________________ Date: ______________________________

DOB: ______________________________ Sex: ______________________________

Phone: ______________________________ email: ______________________________

Living at Home: ______________________________ Other: ______________________________

Next of Kin/Legal Guardian: ____

Phone: ______________________________ email: ______________________________

MEDICAL

Primary Diagnosis: ______________________________ Date of onset: ______________________

Secondary Diagnosis: ______________________________ Date of onset: ______________________

Height: ______________________________ Weight: ______________________________

Diabetes: ______________________________ Insulin: ______________________________

Epilepsy: ____________ Frequency/type of seizures: ______________________________

Date of last seizure: ____

Medications: ____

For: ____

SURGERY DATES

____

Ambulatory: YES NO Assistive Devices: ______________________________

PHYSICAL

Muscle Tone (spasticity, flaccidity, etc.)

Tone in upper extremities: ____

Tone in lower extremities: ____

Tone in trunk: ____

Balance: Sitting: ______________ Standing: ______________ Walking: _______________

Scoliosis: Type: ______________________ Degree: ____________________________

Brace: _____________________ Last X-Ray: __________________________

Kyphosis/Lordosis
Type: ______________________ Degree: ______________________________

Osteoporosis: ________________________ Arthritis: _____________________________

SENSORY

Language: English: _______________ Sign: _______________ Other: ________________

Comprehension: Good: _____________ Fair: ______________ Poor: _________________

Sensory Function: Sight: ________________ Hearing: ______________________________

Tactile: ________________ Continence: __________________________

Allergies/Severity: ____

PHYSIOTHERAPY

Is the patient attending physiotherapy? YES NO

If so, where/who: ____

Precautions to Physiotherapist: ____

REASSESSMENT

When do you recommend this patient be reassessed? _________________________________

(Please complete both sides of this form)

PHYSICIAN'S REFERRAL – TO BE COMPLETED ANNUALLY BY PHYSICIAN

P.O. Box 1820 205-7th Ave. N. Creston BC, V0B 1G0 ph. 250-428-2296 fax 428-2297

I hereby give my permission for ________________________________ to participate in the Creston and District Society for Community Living Therapeutic Riding Program.

Physician's signature: __________________________ Date: ________________________

Physician's name: ____
(Please print clearly)

Physician's address: ____
(Please print clearly)

Phone: _________________ email: _______________________ fax: _______________

NOTE:

- It is important that this form be filled out in detail (e.g. height, weight, etc.) in order for the instructor and physiotherapist to match the rider with the right horse and appropriate support.
- A list of **CONTRAINDICATIONS** and **PRECAUTIONS** to therapeutic riding is enclosed for your information.
- A change in medical condition requires a physician referral update.

. . . .

EXTENDED PHYSICIAN'S REFERRAL

To: Creston and District Society for Community Living Therapeutic Riding Program

Re: ____

The last medical referral submitted on ____________________________ is still valid.

There have been no significant changes to the condition of the client other than as noted below:

____

____

____

Signature of Physician: __________________________ Date: ________________

Print Name: ____

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CONTRAINDICATIONS TO THERAPEUTIC RIDING
(Please forward with Physician's Referral)

CONTRAINDICATIONS:

If a person has any of the following medical conditions, riding is very unlikely to be a beneficial activity for him or her, and is even likely to be harmful. Before an individual is accepted into the therapeutic riding program, the physician and program therapist should be consulted concerning the suitability of riding for that person. The program reserves the right to determine the candidate's suitability for inclusion in the program.

- Moderate to severe agitation (confusion, excitement) and/or very disruptive behaviour
- Spinal instability, including subluxation (partial dislocation) of cervical (neck) vertebrae
- Severe osteoporosis, involves brittleness of the bones and hence the possibility of fractures
- Seizures which are not controlled by medication
- Pathological fractures arising from a condition such as osteogenesis imperfecta (brittle bones)
- Acute stages of arthritis
- Periods of exacerbation of multiple sclerosis
- Open pressure sores or wounds
- The individual is taking medication in type or dosage that induces a mental or physical state that makes riding risky and/or inappropriate
- Hemophilia, a congenital condition of the blood characterized by hemorrhages (bleeding).
- The individual is taking anticoagulant medications (blood thinners)
- Atlanto-axial instability
- Spondylothesis (subluxation of the lower lumbar vertebra on the sacrum)
- Coxarthrosis (degeneration of the hip joint) – riding causes too much stress on that joint
- Detached retina
- Acute herniated intervertebral disk, which may press on spinal nerve roots
- Complete quadriplegia occurring as a result of a spinal cord injury
- Structural scoliosis greater than 30 degrees, excessive kyphosis (rearward increase of the curvature of the thoracic spine) or lordosis (increased forward curvature in the lumbar spine), or hemivertebra (a congenital defect in which one side of a vertebra is incomplete)
- Dislocation, subluxation or dysplasia (abnormal development) of the hip(s) with significant restriction or asymmetry
- Any condition that the instructor, therapist, physician or program does not feel comfortable treating
- After a rhizotomy, a rider should wait at least 6 months before participating in a riding program

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PRECAUTIONS AND POSSIBLE CONTRAINDICATIONS TO THERAPEUTIC RIDING
(Please forward with Physician's Referral)

If a person has any of the following conditions, riding may not be beneficial, and in some instances, may even be harmful. Before an individual is accepted into the therapeutic riding program, the physician and program therapist should be consulted concerning the suitability of riding for that person. The program reserves the right to determine the candidate's suitability for inclusion in the program.

- Prolonged use of Dialantin
- Incontinence
- Hydrocephalus - presence of shunt(s)
- Sensory deficits – unable to feel certain parts of the body
- Heterotopic ossification
- Significant allergies to horse hair, dust, hay etc.
- Recent surgery **(Riders must have written consent from physician before returning to program)**
- Serious cardiac condition
- Craniotomy (any surgical procedure on the skull)
- Diabetes
- Peripheral vascular disease, resulting in poor circulation in the extremities
- Obesity (See Horse Load Guidelines)
- Extreme fatigue
- Arnold Chiari malformation, a congenital defect in which the cerebellum and medulla oblongata protrude through the skull, down into the spinal canal and which is most often associated with other disabilities such as spina bifida
- Any spinal fusion, whether natural or due to surgical intervention (e.g. Harrington rod)
- History of skin breakdown and/or skin grafts over areas of the body that bear weight in riding (seat and legs)
- Tethered cord
- History of substance abuse which has resulted in fragile blood vessels
- Rhizotomy (a surgical procedure in which the roots of the spinal nerves along the spinal canal are cut)

ATLANTO-AXIAL X-RAY VERIFICATION / DOWN SYNDROME

P.O. Box 1820 205-7th Ave. N. Creston BC, V0B 1G0 ph. 250-428-2296 fax 428-2297

All rider candidates who have Down Syndrome should have a detailed neurological examination before being accepted for riding.

The American Academy of Pediatrics and the Committee on Sports Medicine recommends the following:

1. When an individual is shown, upon x-ray examination, to have a distance exceeding 4.5 mm between the odontoid process of the second cervical vertebra (C2) and the arch of the first cervical vertebra (C1), he or she should restrict sport activities and undergo regular clinical evaluations to monitor the instability.
2. It is not mandatory to regularly examine individuals who have previously been shown, on x-ray examination, to have a normal atlanto-axial joint.
3. People with Down Syndrome who have no evidence of atlanto-axial instability may participate in all sports. Medical follow-up is not required unless an individual experiences musculo-skeletal or neurological signs or symptoms of atlanto-axial instability.

Rider: ______________________________________ DOB: ______________________

Address: ____________________________________ Phone: _____________________

Next of Kin/Guardian: _________________________ Phone: _____________________

Date of X-Ray: ____

Result:

____

____

____

Physician's signature: ____

Name of Physician: ____

Phone: ___________________ fax: _________________ email: __________________

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.

PHYSICAL THERAPY EVALUATION

P.O. Box 1820 205-7th Ave. N. Creston BC, V0B 1G0 ph. (250) 428-2296 fax 428-2297

(Please complete this evaluation as fully as possible to enable us to plan a therapy program which will benefit the individual client)

Name: ________________________________ DOB: ________________________

Diagnosis: ____

Surgeries Performed (with dates): ____

____

Other Pertinent Medical History: ____

____

Muscle Strength:
Gross: ____

Specific Weaknesses: ____

Joint ROM:
Gross: ____

Specific Limitations: ____

Muscle Tone: ____

Balance: Sitting: ______________ Standing: ___________ Walking: ____________

Coordination:
Gross Motor: _________________________ Fine Motor: ______________________

Reflex Activity:
Developmental: ____

Tendon reflexes: ____

Pain:
Character: ___________________________ Location: ________________________

Caused by: __________________________ Relieved by: _____________________

Sensory Impairments: ____

Perceptual Problems: ____

Communication Difficulties: ____

Skin Condition: ____

Functional Abilities:
Mobility: ____

Transfers: ____

ADL Skills: ____

Problem Plans & Goals

1. ____

2. ____

3. ____

4. ____

Additional Comments:

Signature of RPT: ____

Name of RPT: ____

Address: ____

Phone: ________________ fax: ________________ email: ________________

SESSION REGISTRATION FORM

P.O. Box 1820 205-7th Ave. N. Creston BC, V0B 1G0 ph. 250-428-2296 fax 428-2297

DATE OF SESSION: *September 3, 2008 - October 10, 2008*

NUMBER OF WEEKS: 6 weeks = $90 plus the annual $20 insurance fee

Name of Rider: ____

Address: ____

Phone: ______________________ email: ______________________

Legal Guardian: ____

Address: ____

Phone: ______________________ email: ______________________

I am registering the above rider for the above noted session. All the appropriate forms have been completed, signed, submitted and are on file with CDSCL.

- Intake/Referral for Services (where applicable)
- Rider Application/Profile Form (mandatory)
- Atlanto-axial X-Ray Verification for riders with Down Syndrome (where required)
- Consent for release of information (where applicable and/or as required)
- Physician Referral Form (mandatory)
- Liability Release/Waiver (mandatory)
- Photograph/Video Release/Non Consent Form (mandatory)
- Authorization/Non Authorization for Emergency Medical Treatment (mandatory)
- Emergency Profile (mandatory)

The following form is required on an annual basis:
- Physician Referral Form

Interested in Rider Level Programs: yes no Which one (if known) ______________________

Signature of Rider: ______________________________ **Date:** ______________

Signature of Legal Guardian: ______________________________ **Date:** ______________

Signature of Witness: ______________________________

Signature of Program Director: ______________________________ **Date:** ______________

VIDEO RELEASE/LIABILITY WAIVER

P.O. Box 1820 205-7th Ave. N. Creston BC, V0B 1G0 ph. 250-428-2296 fax 428-2297

Name of Rider: ____

PHOTO/VIDEO RELEASE/NON-CONSENT

While on outings and during our daily programs many exciting situations arise. By photographing or video taping these events we can share them with you, family members, caregivers, and others and utilize them to demonstrate the "good works" for our organization. For this reason, we ask permission to share these photographs and or videotapes with the general public.

I,____of___________________________
Name Address

Give permission for CDSCL to:

1. Share photographs with the general public Yes ( ) No ( )

2. Share video tapes with the general public Yes ( ) No ( )

3. Publish photographs/videos/stories on the internet Yes ( ) No ( )

Signature of Rider: ____ date: ____________

Signature of Witness: ______________________________________

Signature of Legal Guardian: _________________________________ date: ____________

Signature of Witness: ______________________________________ date: ____________

RIDER LIABILITY WAIVER

I acknowledge that the sport of horses is a risk sport and that I am participating at my own risk and in full knowledge of the hazards and potential hazards which are inherent in this sport. I further acknowledge the inherent risk in riding, working around horses (mounted and dismounted) and viewing horse activities, which include bodily injury to both horse and rider which can result from therapeutic riding as well as normal use, competition and schooling. It is hereby also understood that no helmet or protective equipment can protect me against all foreseeable injury.

I hereby assume all risk and hereby absolve Creston and District Society for Community Living, its members and volunteers, Kootenay Region Association for Community Living, their members and volunteers from all responsibility, liability or claims of any nature and kind which I may have arising from participation in the Therapeutic Riding Program including but not limited to bodily injury or death, and damage to or loss of my property arising from any cause whatsoever, including negligence of one or more of the organizations or individuals referred to herein.

I hereby declare that in signing this document that I have read and fully understood and agree to the terms and conditions stated herein and that it is binding upon my executors, heirs and assigns.

Signature of Rider: ____ date: ____________

Signature of Legal Guardian: _________________________________ date: ____________

Signature of Witness: ______________________________________ date: ____________

EMERGENCY MEDICAL TREATMENT

P.O. Box 1820 205-7th Ave. N. Creston BC, V0B 1G0 ph. (250) 428-2296 fax 428-2297

Name: ____

Address: ____

Phone: ____

Emergency Contact Name: ____________________________________

Relationship: ______________________ Phone: _________________

Care Card Number: ____

Physician Name: _____________________ Phone: _________________

Medications: ____

Allergies: ____

Other: ____

PLEASE ONLY SIGN ONE – CONSENT OR NON-CONSENT

CONSENT FOR EMERGENCY MEDICAL TREATMENT

In case of emergency, **I give permission** to Creston and District Society for Community Living to secure medical treatment including x-rays, surgery, hospitalization and medication.

Signature of Rider: __________________________ Date: ______________

Signature of Legal Guardian: ____________________ Date: ______________

Witness: ________________________________

NON CONSENT FOR EMERGENCY MEDICAL TREATMENT

In case of emergency, **I do not give permission** to Creston and District Society for Community Living to secure medical treatment including x-rays, surgery, hospitalization and medication.

Signature of Rider: __________________________ Date: ______________

Signature of Legal Guardian: ____________________ Date: ______________

Witness: ________________________________