BARABOO RIVER EQUINE-ASSISTED THERAPIES, INC.

Rider Registration

Name____Birthdate________________________________

Address____Home Phone_____________________________

City, State, Zip_________________________________Cell Phone_______________________________

E-mail____Your Employer___________________________

Name of Spouse_________________________________Spouse's Employer_______________________

____

IF UNDER 18 YEARS OF AGE, COMPLETE THE FOLLOWING:

Name of School____

Name of Parent/Guardian________________________Employer_________________________________

Address____Work Phone______________________________

City, State, Zip____

Spouse Employer________________________________Work Phone______________________________

EMERGENCY CONTACT

Name____Phone___________________________________

Relationship____________________________________Cell_____________________________________

Are you currently enrolled in:

Physical Therapy ( ) Yes ( ) No

Occupational Therapy ( ) Yes ( ) No

Speech Therapy ( ) Yes ( ) No

Explain therapy involvement____

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Do you receive funding through any of the following:

Children's Long Term Support (CLTS)	( ) Yes ( ) No
Lakeland Care District (LCD)	( ) Yes ( ) No
Care Management Organization (CMO)	( ) Yes ( ) No
Other	( ) Yes ( ) No

If yes, Case Manager *(only if B.R.E.A.THE. services are funded through your contract)*

Name____

Address____

Phone____

HOW DID YOU HEAR ABOUT BARABOO RIVER EQUINE-ASSISTED THERAPIES, INC.?

( ) Newspaper ( ) Radio/TV ( ) Poster ( )Volunteer ( ) Another Organization ( ) Other___________

HAVE YOU RIDDEN A HORSE BEFORE? ( ) YES ( ) NO

ARE YOU WILLING TO ATTEND EVERY CLASS? ( ) YES ( ) NO

IS THERE A PARENT, GUARDIAN, SIBLING, OR OTHER PERSON INTERESTED IN HELPING DURING THE RIDER'S CLASS TIME? IF SO, NAME____

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ADDITIONAL INFORMATION OR COMMENTS YOU FEEL WOULD BE HELPFUL TO BARABOO RIVER EQUINE-ASSISTED THERAPIES, INC.____________________________________

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BARABOO RIVER EQUINE-ASSISTED THERAPIES, INC.

RIDERS MEDICAL HISTORY & PHYSICIAN' STATEMENT

Participant:_________________________________ DOB:_________Must have info to match to a horse.
Height:________Weight:________ Body shape: Apple_______ Pear_______ String bean________
Address:____
Primary Diagnosis:________________________________Date of Onset:__________________________
Secondary Diagnosis:_____________________________Date of Onset:____________________________
Shunt Present: Y N Date of last revision:____
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices:____
For those with Down Syndrome: AtlantoDens Interval X-rays, Date_________________Result: + -
Neurologic Symptoms of AtlantoAxial Instability:____
Please indicate current or past special needs in the following system/areas, including surgeries:

	Yes	No	Comments
Auditor			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Physician's Statement
Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the Baraboo River Equine-Assisted Therapies, Inc., will weigh the medical information given against the existing precautions and determine eligibility for participation.
Name/Title_______________________________________MD DO NP PA Other____________
Signature:____Date________________
Address:____
Phone:_______________________________________License/UPIN Number__________________

MEDICATIONS: (include prescription, over-the-counter, name, dose, and frequency)____________________________
____
____
____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed).

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

PSYCHO/SOCIAL FUNCTION: (i.e., work/school including grade completed, leisure interests, relationship-family structure, support systems, companion animals, fears, concerns, etc)____
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____

GOALS: (i.e., Why are you applying for participation? What would you like to accomplish?)_______________________
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The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Medical/Surgical
Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebro-vascular Accident)

Neurologic
Hydrocephalus/shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis due to Spinal Cord Injury
Seizure Disorders

Secondary Concerns
Behavior problems
Age less than two years
Age two-four years
Acute exacerbation of chronic disorder
Indwelling catheter

BARABOO RIVER EQUINE-ASSISTED THERAPIES, INC.

LIABILITY, PHOTO, MEDICAL CONSENT RELEASE
NEEDS TO BE COMPLETED FOR ALL RIDERS, VOLUNTEERS and STAFF
PARENT/GUARDIAND SIGNATURE FOR ANY PARTICIPANT UNDER AGE OF 18

LIBILITY RELEASE
I/ my child/ my ward would like to participate in the Baraboo River Equine-Assisted Therapies, Inc. (B.R.E.A.THE.) Program as a rider, volunteer, or staff person. I acknowledge the risk and hazardous nature of horse activities and horseback riding. However, I feel that the possible benefits are greater than the risks assumed. I hereby, intending to be legally bound for myself, my heirs, assigns, executors or administrators, waive and release forever all claims for damages against Baraboo River Equine-Assisted Therapies, Inc., its Board of Directors, instructors, therapists, aides, volunteers, horse owner and/or employees and Ken and Carla Cady as stable and property owners for any and all injuries and/or losses that I/ my child/ my ward may sustain while traveling to or from, or participating in any B.R.E.A.THE activities.

Signature:____ Date:_________________________________

Parent or Guardian:____Date:_________________________________

Wisconsin State Statutes Sec. 95.481
Notice: A person who is engaged for compensation in the rental of equines or equine equipment or tack in the instruction of a person in the riding or driving of equine or in being a passenger upon an equine is not liable for injury or death of a person involved in equine activities resulting from the inherent risks of equine activities, as defined in Section 895.481 (1) (e) of the Wisconsin State Statutes.

PHOTO RELEASE
I____DO____DO NOT consent to and authorize the use and reproduction by Baraboo River Equine-Assisted Therapies, Inc., of any and all photographs and any other audio/visual material taken of me for promotional material, educational activities, exhibitions or an other use for the benefit of the program.

Signature:____Date:___________________________________

Parent or Guardian:____Date:___________________________________

MEDICAL TREATMENT CONSENT PLAN
In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or any other use for benefit of the agency.
I authorize Baraboo River Equine-Assisted Therapies, Inc. 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 emergency medical treatment.

This authorization includes x-ray, 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.
Consent Signature____Date___________________________________

MEDICAL TREATMENT 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.

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

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Non Consent Signature____Date_________________________________

BARABOO RIVER EQUINE-ASSISTED THERAPIES, INC.

NEEDS TO BE COMPLETED FOR ALL VOLUNTEERS AND STAFF

To ensure a safe environment while engaging in therapeutic interaction with horses as stated in the Baraboo River Equine-Assisted Therapies, Inc. (B.R.E.A.THE.) Mission Statement, I acknowledge the expectations required of all B.R.E.A.THE. volunteers and staff. I am aware that disregarding any one of these expectations will result in first a warning, second a reprimand, and if a third time occurs, then dismissal from B.R.E.A.THE.

- Safety is the top priority whether grooming and/or tacking the horses, side walking, or handling the horses in or outside of class time.
- Listen to and obey the instructor.
- Follow the posted barn rules which include, but are not limited to:
  - No smoking.
  - No running or yelling.
  - No “horse play”.
  - No hand feeding the horses.
- Follow Dress Code for personal safety and professionalism.
- Be courteous and work as a team member. This includes:
  - Speaking positively about B.R.E.A.THE. personnel, volunteers, and participants.
  - Understanding the role of Side Walker vs. Horse Handler.
  - Asking questions when not fully understanding what is needed.
  - Arriving in punctual manner.
  - Contacting an appropriate substitute when a conflict arises that would cause unavailability.

Signature____Date__________________________________

Volunteer and Staff Confidentiality Statement

Divulging confidential information concerning any information of a sensitive nature to an unauthorized person is grounds for immediate discharge. We ask that you practice loyalty to the riders, their families, and to each other.

I am fully aware Baraboo River Equine-Assisted Therapies, Inc. serves children and adults who are challenged with various disabilities, including but not limited to, mental and physical disabilities, mental illness, dependency issues, depression, anxiety and more.

Information about a participant’s condition, care treatment, personal affairs and records is confidential. Such may not be discussed with anyone including physicians, therapists, employees, or volunteers who are responsible for the participant’s care, unless the participant, their parent or guardian has authorized release of information, or unless compelled by law to do so. Carelessness or thoughtlessness leading to the release of student information may result in immediate dismissal.

Signature____Date__________________________________

Honesty Acknowledgment Statement

I understand that this is an application for, and not a commitment of promise, of a volunteer opportunity. I certify that I have, and will provide information, throughout the selection process, on this volunteer application and in an interview with Baraboo River Equine-Assisted Therapies, Inc., personnel that is true, correct, and complete to the best of my knowledge. I certify that I will answer all questions to the best of my ability and that I have not, and will not, withhold any information that will unfavorably affect my application for a volunteer position. I understand that misrepresentations or omissions may be cause for immediate rejection of my application for a volunteer position with Baraboo River Equine-Assisted Therapies, Inc., or termination as a volunteer.

Signature____Date__________________________________

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