



Enrollment Packet

PARTICIPANT'S APPLICATION AND HEALTH HISTORY

GENERAL INFORMATION

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Phone: _____ E-mail _____ Alternative #: _____

Address: _____

Employer/School: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone (if different from above): _____

Referral Source: _____ Phone: _____

How did you hear about the program? _____

HEALTH HISTORY

Diagnosis Date of Onset: _____

Please indicate current or past special needs in the following areas:

Yes

No

Vision	_____	_____
Hearing	_____	_____
Sensation	_____	_____
Communication	_____	_____
Heart	_____	_____
Breathing	_____	_____
Digestion	_____	_____
Elimination	_____	_____
Circulation	_____	_____

Emotional/Mental Health _____

Behavioral _____

Pain _____

Bone/Joint _____

Muscular _____

Thinking/Cognition _____

MEDICATIONS (include prescription, over-the-counter; name) _____

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

PHYSICAL FUNCTION (Le. Mobility skills such as transfers, walking, wheelchair use, driving, bus riding) _____

PSYCHO/SOCIAL FUNCTION (Le. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animal, fears/concerns) _____

What are your GOALS? What would you like to accomplish with therapeutic horseback riding? _____

PHOTO RELEASE

I DO _____

I DO NOT _____

Consent to and authorize the use and reproduction by of any and all photographs and any other audio/visual materials taken of me for promotional material educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

RIDER'S APPLICATION

TO BE COMPLETED BY PARENT, CAREGIVER OR THERAPIST
PLEASE INCLUDE ANY OTHER INFORMATION WHICH WOULD BE HELPFUL.
USE THE BACK OF THIS FORM OR ADDITIONAL SHEETS IF NEEDED.

Rider's Name: _____

Long term goals: _____

Short term goals: _____

Specific activities/ exercises being used to achieve these goals: _____

Behaviors to be encouraged: _____

Behaviors to be discouraged: _____

Rider's likes, dislikes, interests, hobbies: _____

What is the rider's major challenge? _____

Behavior patterns which may affect our work with this rider: _____

What is the most effective method used in communicating with this rider? _____

Guardian Name: _____

Telephone _____ E-Mail _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: Preferred Medical Facility: _____

Health Insurance Company: _____

Policy: _____

Allergies to Medications: _____

Current Medications: _____

In the event of an emergency, contact: _____

Name: Relation: Phone: _____

Name: Relation: Phone: _____

Name: Relation: Phone: _____

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 Hearts staff or volunteers 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.

Consent Plan

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.

Date: _____ Consent Signature: _____
(Client, Parent or Legal Guardian)

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. In the event emergency treatment/aid is required, I wish the following procedures to take place: _____

Date: _____ Consent Signature: _____
(Client, Parent or Legal Guardian)

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

This should be completed by your doctor or therapist.

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Seizure Disorder/Type? _____ Controlled: Y N Date of Last Seizure: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs _____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: _____

For those with Down Syndrome: Atlantoaxial Interval X-rays, date: _____ Result: _____

Neurologic Symptoms of Atlantoaxial Instability: _____

Please indicate current or past special needs in the following systems/area: _____

To my knowledge, there is no reason why this person cannot participate in supervised therapeutic horseback riding. However, I understand that Hearts will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional in the implementation of an effective equine activity program.

(e.g. PT, Of, SLP, Psychologist, etc.)

Name/Title: MD _____ DO _____ NP _____ PA _____ Other _____

Date: _____

License/UPIN Number: _____

Signature: _____

Address: _____

Signature: _____

PARTICIPANT'S CONSENT FOR RELEASE OF INFORMATION

I hereby authorize: the staff of Hearts Therapeutic Riding to release information from the records of:

_____ *(participant's name)*

The information is to be released to: _____
(center or therapist's name)

For the purpose of developing an equine activity program for the above-named participant. The information to be released is indicated below:

- Medical History
- Physical Therapy evaluation, assessment and program plan
- Occupational Therapy evaluation, assessment and program plan
- Mental Health diagnosis and treatment plan
- Individual Habilitation Plan CI.H.P.J
- Classroom Individual Education Plan CI.E.P
- Psychosocial evaluation, assessment and program plan
- Cognitive-Behavioral Management Plan
- Other: _____

Signature: _____ **Date:** _____
Printed Name

EQUINE WAIVER & RELEASE FORM

This Waiver and Release from tort and civil liability is made this _____ day of _____ (mo.), _____ (yr.), between Equine Activity Participant _____ (Participant) and Hearts Therapeutic Riding.

1. Participant understands that there are risks inherent in dealing with horses and ponies (equine activity). For example, Participant understands that some of the inherent risks include:
 - a. The propensity of an equine to behave in ways that may result in injury, death, or loss to persons on or around the equine;
 - b. The unpredictability of an equine's reaction to sounds, sudden movements, unfamiliar objects, persons, or other animals;
 - c. That there may be hazards, including, but not limited to, surface or subsurface conditions;
 - d. The possibility of a collision with another equine, another animal, a person, or an object;
 - e. The potential of an equine activity Participant to act in a negligent manner that may contribute to injury, death, or loss to the person of the Participant or to other persons, including, but not limited to, failing to maintain control over an equine or failing to act within the ability of the Participant;
2. With full understanding of the inherent risks involved in equine activity, some of which have been described in Paragraph 1 above, Participant agrees to wave, release and hold harmless HTR from all tort and civil liability arising from or related to participation in equine activity. This agreement to waive, release and hold harmless includes not only HTR but their employees, volunteers, agents, and independent contractors whether they be trainers, veterinary personnel, farrier's equine care providers, and maintenance personnel and the like.
3. Participant further understands the examples of the equine activity taking place on or with an equine, including, but not limited to:
 - a. Riding, jumping, showing, competitions, fairs, trade shows, trail riding, and the like;
 - b. Teaching, instructing, and evaluation, both the rider and the equine;
 - c. Routine care and feeding of the equine (Boarding), including veterinary and farrier;
 - d. Traveling, loading and unloading of equines;
 - e. Breeding activity, both natural and artificial.
4. This Voluntary Waiver Agreement is made and entered into in the State of Texas and shall be enforced and interpreted under the courts and laws of the State of Texas.

“WARNING”

“Under Texas law (Chapter 87, civil practice and remedies code), an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities.”

5. Participant agrees that Participant has been given sufficient time to read, understand, and ask questions, if any, concerning the nature and scope of this Voluntary Waiver Agreement.

Lisa Rivers _____ **Date:** _____

Stable / Farm Owner.

Participant

or Author. Rep

_____ **Date:** _____

For: Hearts Therapeutic Riding

Parent or Guardian if Participant is a minor



RIDER AGREEMENT

TERMS AND CONDITIONS

These policies are established to ensure safe and effective riding lessons.

Lesson Policy Standard:

A lesson is 45-50 minutes in length and is to consist of horse preparation, mounting each client and tack adjustments, exercises while mounted, cool down time, and dismounting and for some riders, un tacking, grooming and putting horse back to his pasture. Please note we consider a lesson starting when the client enters the arena area through the large entry gate. The instructor additionally has the responsibility of safety for clients, volunteers, and horses at all times so therefore, the instructor has the right to deviate from the above lesson outline when safety is a concern. Lessons may be privately done or in small groups, according to the needs of each rider and as determined by the Instructor.

Payments:

Therapeutic riding lessons are to be paid at the beginning of each month for the upcoming month by credit card.

- In case of missed lessons due to illness or vacations with a minimum of 24 hour notice, lessons will be made up at a schedule agreeable by rider and instructor. Missed lessons without 24-hour notice and no shows will be charged a \$25 fee and will not be made up unless special circumstances require waiving of the policy. There will be no carry over lessons to the following month. It will be the responsibility of the family to contact Lisa Rivers, by text or email for cancellations or make up lessons.

Weight limits:

Our weight limit for riding is approximately 200 pounds, depending on the rider's ability to maintain good balance. No weight limit applies for ground work activities.

Basic Guidelines:

I understand that it is my responsibility **prior to entering the arena** to inform the instructor of any new medical or physical problems which may impact my safety or ability to perform correctly during my scheduled therapeutic riding lesson. I further agree to handle all other questions or suggestions according to Hearts Therapeutic Riding Program's policy listed at the end of this contract.

I understand that lesson times are planned and that I need to be on time. If I am late more than 15 minutes from my scheduled time, my mount will be un-tacked, unless I have made prior arrangements. I further understand that even if I am late, the time for ending the lesson will remain as scheduled. The only condition for extending my lesson time is if the instructor is not present at the scheduled lesson beginning time. I further accept that the instructor is the only person with authority to cancel any lesson. The only considerations for approved cancellation of a lesson are bad weather conditions (thunderstorms, extreme cold, etc.), schedule conflicts with the instructor's commitments, a client's medical absence with a written doctor's excuse, or a death in the family. Make-up lessons will only be scheduled for the above described lesson cancellations. **All approved make-up lesson scheduling will be arranged between the instructor and parent/guardian.**

I understand that proper attire must be worn for therapeutic riding lessons. Proper attire is pants, shirt, protective shoes/boots and SEI-ASTM approved riding helmet which fits properly with an attached harness. A helmet can be provided but it is highly suggested that each rider brings their own helmet that fits correctly. **Ask us where to purchase a helmet and have your helmet fitted.**

I further accept that Hearts Therapeutic Riding reserves the right to release a client due to unsafe situations, physical stress to the client resulting from riding and/or any safety/medical problems that may arise.

Client's information files will be held in confidentiality and only shared when necessary to assure the safety of a client in the treatment or during an official incident review. I am aware of the inherent risks of being around horses and mounted on horseback and riding. I further understand that I must be careful while on the property of Hearts Therapeutic Riding particularly while horses are being handled. Hearts Therapeutic Riding cannot and does not assume any liability for accidents, injury, or death to person or persons. I further have reviewed and understand the content of Texas' Liability Law which is posted at the pasture/arena entrance gate and in the barn. Likewise, I accept full responsibility for friends and visitors accompanying myself on Hearts Therapeutic Riding property.

Program Enrollment Policy:

Enrollment in the Hearts Therapeutic Riding Program begins upon program's receipt of a fully completed enrollment packet. Make every effort to get the packet turned in prior to a scheduled lesson but if approved by the instructor, bring the packet to the first lesson.

General Conduct Policy for Parents, Clients, and Guests during a Hearts Therapeutic Riding lesson:

Parent/Client waiting area:

Parent/Client waiting area is located on the tack room porch, picnic tables or in your vehicle. You can watch the lesson at the arena unless it is distracting for the rider.

Arrival to lesson:

If a previous lesson is in progress or dismounting, quietly go to parent/client waiting area.

All clients are to wait at the parent/client waiting area until a volunteer or instructor comes to escort them. This is for the safety of everyone.

The only people who are to be in the arena/mounting area are the instructor, volunteers and clients that are getting ready to mount for the current lesson.

If you need to talk to the instructor about medical or physical problems which may have a safety implication for the current lesson, please do so before the mounting phase of the lesson gets started.

During the lesson:

To ensure the best possible riding experience, please do not speak with riders during lessons.

While a therapeutic riding lesson is in progress all parents, family members, and guests must stay in the waiting areas which are the roped off picnic table area, the classroom or their vehicles. You may only enter the arena if asked by the instructor or volunteer. No loud noises (clapping, door slamming on cars, loud talking/laughing, calling to clients, etc.) No umbrellas or flash cameras while horses are present. No ball playing, tag games, or fast type movement games allowed before, during or after lesson schedule times. Please do not bring your dog to the property.

This policy is for the safety of all. During a scheduled therapeutic riding lesson, our instructor and volunteers must maintain lesson focus at all times for the safety of our clients.

After therapeutic riding lesson:

After the lesson, the rider will be returned to the parent/guardian.

Confidentiality:

All rider/client information is confidential, and records are kept locked in a file cabinet. Staff and volunteers are asked to not repeat what is heard in riding lessons and all relationships are to remain professional.

Question and Suggestion Policy:

If a client or parent/guardian has a question or suggestion pertaining to a client, problem, complaint, suggestion, etc. please email or call the Executive Director, Lisa Rivers at (512)484-8480 or lisarivers302@gmail.com

I the undersigned have read and understand the above contract which I agree to abide by in total and I have received a copy of this contract. I further understand that if any of Hearts Therapeutic Riding contract policies are not followed Hearts Therapeutic Riding has the right to cancel this contract.

Rider Name: _____ **DOB:** _____

Parent/ Guardian: _____

Address: _____

Phone: _____ **Email:** _____

Rider Signature: _____

Parent/guardian Signature: _____

Program Director Signature: _____

Date: _____

Please sign and turn this last page into Hearts Therapeutic Riding and keep the agreement for your records. Thank you.