SPECIAL TROOPERS ADAPTIVE RIDING SCHOOL
33148 K22—Sioux City, IA 51108—www.scstars.org—P: 712.239.5042—F: 712.224.3471

PARTICIPANT REGISTRATION FORM - SPRING 2023

Please print legibly

PARTICIPANT NAME: _____ Age: _____ DOB: _____

Parent/Guardian Name(s): _____

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

Primary Phone: _____ Secondary Phone: _____

Email: _____ Best way to contact you: Email ☐ Phone ☐ or Text ☐

Rider T-shirt Size: Youth ☐ _____ Adult ☐ _____

Diagnosis or Description of Disability: _____

Current Medications: _____

Height: _____ Weight: _____ (Required to Participate.)

Please answer the questions below to the best of your ability and provide detail as needed for participant.

Balance Ability: _____

Cognitive Ability: _____

Does the participant know Left and Rights? Yes ☐ No ☐

Ability to Communicate: _____

Attention: _____ Disposition/Social/Behavior: _____

History of Animal Abuse: Yes ☐ No ☐ Comments: _____

Any recent changes to note (behaviors, medications, health, etc.): Yes ☐ No ☐ If yes, please provide more details:

_____

_____

What goals would you like the participant to work on this year? _____

_____

Additional Information: _____

_____

***STARS, Inc. reserves the right to refuse or discontinue services at any time for current or potential participants if the participant exceeds a safe weight limit or poses other safety concerns of any nature.**

Signature (Self, Parent, or Guardian): _____ Date: _____

Printed Name: _____ Relationship to Participant: _____

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THERAPEUTIC RIDING SESSION SCHEDULE

PARTICIPANT NAME: _____ Age: _____ DOB: _____

Parent/Guardian Name(s): _____

Primary Phone: _____ Secondary Phone: _____

Email: _____ Best way to contact you: Email ☐ Phone ☐ or Text ☐

Returning Riders:

- Registration for SPRING Sessions 1, 2, and 3 are due by December 16, 2022
- On the chart below please mark an X on **ALL** of the days and times you **ARE** available for each session of the current registration.
- *Registrations processed in order of receipt – first come, first served*

SPRING 2023 REGISTRATION

DUE BY Dec 16, 2022

Session ONE (1)			
Week of January 16 thru February 20			
Day/Time	**Mon**	**Tues**	**Wed**
5:30 pm			
7:00 pm			

Session TWO (2)				
Week of March 13 thru April 17				
Day/Time	**Mon**	**Tues**	**Wed**	**Thur**
5:00 pm				
6:00pm				
7:00 pm				

Session THREE (3)				
Week of May 8 thru June 12				
Day/Time	**Mon**	**Tues**	**Wed**	**Thur**
5:00 pm				
6:00 pm				
7:00 pm				

FALL 2023 REGISTRATION

Opens July 15, 2023

Due by August 11, 2023

Registrations processed in order of receipt – first come, first served

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PHYSICIAN'S AUTHORIZATION & PARTICIPANT'S MEDICAL HISTORY

To be completed by Physician. Please fill out completely.

STARS, Inc. is a therapeutic/adaptive horseback riding program designed to benefit the participants physically, socially, and emotionally. In order to assure the fullest possible protection and greatest personal benefit form the program, each rider is required to furnish the following medical information prior to riding in the program.

PARTICIPANT NAME: _____ Age: _____ DOB: _____

Parent/Guardian Name(s): _____

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

Diagnosis: _____ Date of onset: _____

Medications: _____

Height: _____ Weight: _____ (Required to Participate.)

Allergies: _____

Seizure Type: _____ Controlled: Yes ☐ No ☐ Date of Last Seizure: _____

Shunt Present: Yes ☐ No ☐ Special Precautions/Needs: _____

Mobility: Independent ☐ Crutches ☐ Cane ☐ Braces ☐ Walker ☐ Wheel Chair ☐

Persons with Down Syndrome - Atlantoaxial Instability: Positive ☐ or Negative ☐ Date of X-Ray: _____

Please indicate problems and/or surgeries in any of the following areas. If yes, please comment.

AREAS	YES	NO	COMMENT
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Learning Disability			
Cognitive			
Psychological			
Other			

It is my opinion, this participant can receive therapeutic/adaptive horseback riding under the appropriate supervision at Special Troopers Adaptive Riding School, (STARS, Inc.) and understand that STARS, Inc. will determine whether they can safely provide services to this participant.

Physician's Signature: _____ Date: _____

Physician's printed name: _____ Phone: _____

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

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For Printing

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AUTHORIZATION FOR EMERCENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury while receiving services, being on property, or participating in an authorized activity of STARS, Inc., I authorize Special Troopers Adaptive Riding School (STARS, Inc.) to:

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

PARTICIPANT NAME: _____ Age: _____ DOB: _____

Parent/Guardian Name(s): _____

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

In the event the Parent/Guardian listed above cannot be reached, contact:

Contact Name: _____ Relationship: _____ Phone: _____

Contact Name: _____ Relationship: _____ Phone: _____

Physician's Name: _____

Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

CRITICAL HEALTH INFORMATION

(Ex: DNR, Food Allergies, Medication Allergies, etc.) ☐ None ☐ Yes - Please note below

_____

_____

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 below is unable to be reached.

Signature (Self, Parent, or Guardian): _____ Date: _____

Printed Name: _____ Relationship to Participant: _____

NON-CONSENT

*I do **NOT** give my consent for emergency medical treatment/aid in the case of illness or injury. Please note that by signing the non-consent this may exclude you from participating in programming at STARS Inc.*

Signature (Self, Parent, or Guardian): _____ Date: _____

Printed Name: _____ Relationship to Participant: _____

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PAYMENT CONTRACT & AGREEMENT

PARTICIPANT NAME: _____ Age: _____ DOB: _____

Parent/Guardian Name(s): _____

Billing Address: _____ City: _____ State: ____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____ Preferred method of contact for invoices: Email ☐ Mail ☐

Contact Person (if different than above) for payment & funding:

Contact Name: _____ Relationship to Client: _____

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

Primary Phone: _____ Email: _____

*Participants that list *Veridian* or *Children at Home* will be required to sign additional paperwork. Please note that STARS, Inc. will ONLY submit invoices to Veridian and Children at Home. All other communication with those agencies is the responsibility of the Parent/Guardian. If payment is not received the Parent/Guardian will still be held responsible for payment or pursuing said agency for payment.

STARS, Inc. has five sessions offered throughout the year. Each session is 6-weeks long. Participants attend class once a week throughout the 6-week time frame. The session fee for each 6-week session is due in FULL by the last day of that session. Ground Work Lessons will be approximately 30 minutes per class and Therapeutic Riding will be approximately 60 minutes per class. Class length may vary depending on the number of participants per class.

A $20 deposit will be due at the time of both Spring and Fall registrations. That deposit will be applied to Participant's session fees.

Session Fees:

Every participant receives a 75% discount off session fees when participating at STARS. The Remaining 25% of the participant fee is the responsibility of the Parent/Guardian and must be paid in FULL by the end of each session. If payment is not received in FULL the participant will be unable to participate in future sessions until arrangements are made with the Executive Director of STARS or payment is received. If additional assistance is needed for that 25% PLEASE ASK! There are options available. PLEASE NOTE: Unpaid accounts will risk being turned over to collections if communication is not established with STARS, Inc.

25% fee for Therapeutic Riding (6-week session) - **$189** 25% fee for Ground Work ONLY (6-week session) - **$94.50**

Invoices will be sent out at the beginning of each session followed by monthly statements for all unpaid balances.

By signing below, I agree to the terms set forth in this agreement.

Signature (Self, Parent, or Guardian): _____ Date: _____

Printed Name: _____ Relationship to Participant: _____