What is Therapeutic Horseback Riding?

Therapeutic riding uses equine-oriented activities for the purpose of contributing positively to the cognitive, physical, emotional, and social well-being of people with special needs. Therapeutic riding provides benefits in the areas of sport, recreation, education, and medicine to individuals with a wide range of disabilities.

What are the Benefits of Therapeutic riding?

Physically, therapeutic riding can improve coordination and help normalize muscle tone. It can help improve posture and increase the functional range of motion, muscular strength, and flexibility. Perceptual motor skills and sensory motor skills may also improve. The psychological benefits for the individuals who participate include improved motivation, self-esteem, and confidence. Therapeutic riding enhances the development of cognitive skills and allows the rider to improve socialization skills and learn teamwork.

How do I qualify to participate as a rider with Hands and Hearts for Horses?

You must:

- Be over the age of 5
- Weigh no more than 300 lbs.
- Have sufficient balance to maintain sitting on the horse
- Behave appropriately to maintain safety

The following conditions ARE contraindicated for therapeutic riding:

- Structural scoliosis > 30 degrees
- Positive x-ray for Atalantoaxial Instability
- Tethered cord or Chiari II malformation
- Hip subluxation, dislocation, or degeneration
- Spinal cord injury above T6
- Uncontrolled seizures
- Indwelling catheter
- Hemophilia

The following conditions MAY BE contraindicated for therapeutic riding:

- Osteoporosis
- Heart condition
- Varicose veins
- Recurrent pathological fractures
- Osteogenesis Imperfecta
- Diabetes
- Spina Bifida
- Spinal fusions/spinal instability
- Recent surgeries
- Lordosis or Kyphosis
- Spinal stabilization devices

HEALING HOOF STEPS may be unable to accommodate a potential rider due to resources available and program capabilities (i.e. horses, equipment, and availability of therapist involvement, volunteers, and instructor capabilities). Healing Hoof Steps follows PATH Intl. Precautions and Contraindication guidelines.

Healing Hoof Steps Therapeutic Riding Program consists of a 6 week course led by certified riding instructors. Each week, riders will engage in 1 hour sessions with the horses. 6 Week Therapeutic Riding Course: $300 per rider.

If you have a question as to whether you may qualify to become a rider in our program, please contact Amara Ham 719-238-3711 Amara@healinghoofsteps.org.

Healing Hoof Steps
Therapeutic Riding Program Participant Registration Form

Name: _____ Date of Birth: _____/_____/_____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: (_____)_____Alternate Phone: (____)_____

Email: _____

Parents/Guardian/Spouse Name: _____

Cell Phone:(____)_____ Phone: (_____)_____

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

School/Institution Presently Attending: _____

Physical Therapist: _____ Occupational Therapist: _____

Speech Therapist: _____ Other: _____

Preferred Payment (circle one): Scholarship Application (included)/Insurance/Private Pay

Photo Release: Please initial one and sign.

_____I hereby consent to and authorize without any compensation the use and reproduction by Healing Hoof Steps of any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional printed material, educational activities, or for any other use for the benefit of the program.

_____I do NOT consent to any photograph or other audiovisual materials taken of me/my child/my ward.

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(If participant is under 18 years of age)

Liability Release: _____ (Participant's Name) would like to participate in the Healing Hoof Steps therapeutic riding program. I acknowledge the risks and potential for

risks of horseback riding. However, I feel that the possible benefits to myself/my child /my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Healing Hoof Steps its Board of Directors or Trustees, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my child/my ward may sustain while participating in any Healing Hoof Steps program.
I understand that for the purpose of assisting volunteers in providing safe and responsible services to students, Healing Hoof Steps will release information pertaining to the student's disability as necessary.

Signature: _____ Date: _____

Witness: _____ Date: _____

Healing Hoof Steps
Participant Emergency Medical Treatment Form

Name: _____ Date of Birth: _____

Address: _____

City: _____ State:_____ Zip: _____

Home Phone:_____Cell Phone:_____Work Phone:_____

Physician's Name: _____

Health Insurance Co.:_____

Preferred Medical Facility: _____

Name of Parent/Guardian/Spouse: _____

Address:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Please list current medications: _____

Emergency Medical Treatment:
In the event emergency medical aid/treatment is required due to illness or injury during participation with Healing Hoof Steps or while being on the property, I authorize Healing Hoof Steps to secure and retain medical treatment and transportation if needed.

IN CASE OF EMERGENCY:

Contact: _____ Phone:_____

Contact: _____ Phone: _____

Contact: _____ Phone: _____

HEALING HOOF STEPS
EQUINE ACTIVITY RELEASE/WAIVER, ASSUMPTION OF RISKS AND INDEMNIFICATION AGREEEMENT AND NOTICE OF RISKS

I, _____, do hereby:

1. RELEASE, WAIVE, DISCHARGE, AND COVENANT NOT TO SUE Healing Hoof Steps., its operators, horse owners, and each of them, their officers, agents, employees, leasees, volunteers and participants (all hereafter collectively referred to as REALEASEES) from any and all claims, loss, damage, and liability to the UNDERSIGNED, his/her personal representatives, assigns, heirs, next of kin, or anyone claiming through them, arising out of any liability or negligence of RELEASEES which causes the UNDERSIGNED injury, death, damages, or property damages. I HEREBY COVENANT to hold RELEASEES harmless and indemnify RELEASEES for any claim, judgment, or expense including attorney's fees and costs of litigation RELEASEES may incur arising out of my activities or presence, or travel to or from, at or on the farm, including the playground, or on the property of RELEASEES or at horse shows.

2. UNDERSTAND that my entry onto the farm or premises of RELEASEES, riding, showing, or attending horse shows involves DANGER AND RISK OF INJURY OR DEATH, that conditions of horseback riding and horses change from time to time and may become more HAZARDOUS, and that there is INHERENT DANGER in horse and riding which I appreciate and VOLUNTARILY ASSUME because I CHOOSE TO DO SO. I have observed horses and riding of the type that I seek to participate in and I have inspected the grounds, horse, and equipment provided. I further know that other riders, horses, and participants pose a danger to me; nevertheless, I VOLUNTARILY ELECT TO ACCEPT ALL RISKS connected therewith in my participation. Likewise, I understand that use of the playground and playground equipment is voluntary and that use of the equipment involves DANGER AND RISK OF INJURY OR DEATH. I have personally inspected the playground and VOLUNTARILY ELECT TO ACCEPT AND ASSUME ANY AND ALL RISKS connected therewith in my participation and the participation of my child or children.

3. I verify that no representations or inducements have been made to me to sign this Release. I further expressly agree that the foregoing RELEASE, WAIVER, AND INDEMITY AGREEMENT is intended to be as broad and inclusive as permitted by the law of the state in which I participate in activities conducted by the RELEASES and that if any portion thereof is held invalid, it is agreed that the balance shall, not withstanding, continue in full legal force and effect.

WARNING

Under Florida Equine Liability law, an equine activity sponsor or 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, pursuant to Chapter 773 of the Official Code of Florida Annotated.

THE UNDERSIGNED HAS READ, VOLUNTARILY SIGNED, AND UNDERSTANDS THAT THIS RELEASE AND WAIVER OF ALL LIABLITY AND INDEMITY AGREEMENT FULLY RELEASES HEALING HOOF STEPS FROM ANY LIABILITY TO THE UNDERSIGNED.

READ CAREFULLY BEFORE SIGNING!

Participant's Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

(if participant is under 18 years of age)

HEALING HOOF STEPS
Rider's Medical History and Physician's Statement

Name:_____ Date of Birth: _____

Address: _____

City:_____ State:_____ Zip:_____

Name of Parent or Guardian: _____

Diagnosis: _____

Date of Onset: _____Height _____ Weight _____

** **For Persons with Down syndrome**:
* Negative Cervical X-ray for Atlantoaxial Instability. ____Yes ____ No **X-ray Date:**_____
* Negative for clinical symptoms of Atlantoaxial Instability. ____Yes ____ No

** **For Persons with Scoliosis**: Degree of Scoliosis: _____

Seizure Type _____ Controlled:____Yes ____No

Date of Last Seizure:_____ Tetanus Shot: ____Yes ____ No **Date:** _____

Medications: _____
_____

Mobility	**YES**	**NO**
Independent Ambulation		
Walker		
Crutches		
Cane		
Braces		

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center 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 profession (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician's Signature: _____

Physician's Name (Please Print): _____ Date: _____
Address: _____ City:_____
State: _____ Zip: _____ Phone Number: (_____) _____

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

Areas	**YES**	**NO**	**Comments**
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Comments: _____

_____

_____

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