



PO Box 172, Ridgway, PA 15853
www.bigmaplefarmnt.net
bmfntinc@gmail.com
(814) 387-3571

Dear Friend,

Thank you for your interest in Big Maple Farm's Natural Therapies, Inc. To become a "BMFNT" participant, it is necessary to have the enclosed forms completed and returned to us as soon as possible. There may be a waiting period to get a scheduled session time depending on openings. We will be in touch with you. The enclosed forms are as follows:

Participant Registration Information, Parent/Student Release - these can be completed by you. Please sign where indicated and feel free to go into as much detail as needed.

Student Medical History, Physician's Authorization - to be completed by the physician most familiar with the participant. Sign these as necessary.

Physical Therapy Assessment - in the event that the participant is being treated by a Physical Therapist and/or Occupational Therapist - we need their input to design a quality riding program.

The demands on a program instructor and director are many. Above all, we need to know as much about our participants as possible. Upon receipt of these forms, we may have to consult with your doctors and/or therapists to work with them and design a program best suited to the individual. All information received is treated as highly confidential.

A registration fee of \$30.00 is payable **once per calendar year**. The fee is to be submitted with the participant's application to participate in a session of lessons, and it is indicated on that form. The registration fee will be used to supplement current administrative costs and program insurance.

Animal Session Fee is \$25.00 per lesson. Participants are asked to pay \$25.00 per lesson if they are able to pay that amount. In the event that partial or full sponsorship for lessons is needed, we ask the rider to help us find a sponsor for them. BMFNT does not want to turn any participant away for financial reasons.

If you have not visited the program, please call for an appointment at 814-387-3571. Please do not wait for us to call you. We look forward to meeting and working with you.

Sincerely,

Amanda Balon
President



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RIDER REGISTRATION INFORMATION

Participant's Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Parent/Legal Guardian: _____ Phone: _____

Parent email (please print): _____

Parent employer: _____

Emergency Contact (name and number): _____

School District: _____ School Attending: _____

Participant's Physician/Medical Center: _____ Phone: _____

Physician's Address: _____

Participant's physical, emotional or mental Disability: _____

Date of Onset: _____

If physical disability, limbs affected: _____

Allergies: Yes _____ No _____ If yes, please list _____

Please indicate if the Participant has any of the following health concerns:

Respiratory disease	Yes	No
Heart disease	Yes	No
Fainting	Yes	No
High blood pressure	Yes	No
Shunt	Yes	No
Heat exhaustion	Yes	No
Seizures	Yes	No
Are seizures controlled?	Yes	No
Skin problems (current and/or past)	Yes	No

Height:		Weight:	
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Bladder problems (circle one): Yes/No

If yes, describe _____

Visual problems (circle one): Yes/No

If yes, describe _____

Hearing problems (circle one): Yes/No

If yes, describe _____

Subluxing or dislocating hip (circle one): Yes/No

If yes, describe _____

Current medication and dosage _____

Physical aids (check if applicable):

Wheelchair: _____ Walker: _____ Canes: _____ Glasses: _____ Contact lens: _____ Braces: _____

Crutches: _____ Hearing Aid: _____ Other (i.e. splints): _____

Specify: _____

Ambulatory status (please check):

Uses wheelchair: _____ Walks with assistive devices: _____ Non-Ambulatory: _____ Walks independently _____

Please include any special problems (i.e. violent outbursts, emotional withdrawal, fears, any limitations, etc.) _____

Any additional information:



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LIABILITY RELEASE _____ (Participant's name) would like to participate in the Big Maple Farm's Natural Therapies, Inc. program. I have discussed the risks and problems of horseback riding, on ground horsemanship skills, and on ground small animal skills with my own/son's/daughter's/ward's doctor and acknowledge the risks and potential for risks in this activity, however, I feel that the possible benefits to myself/my son/my daughter/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 Big Maple Farm's Natural Therapies, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward and immediate family may sustain while participating in the Big Maple Farm's Natural Therapies, Inc. Program.

Date: _____ Signature: _____

Relationship: _____
(self/mother/father/ Legal guardian)

Witness: _____
(Must be a board member when turning form in) – Thank you for your cooperation!

PHOTO RELEASE: OPTIONAL I hereby consent to and authorize the use and reproduction by Big Maple Farm's Natural Therapies, Inc. of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.

Date: _____ Signature: _____
(client, parent, or guardian)

PLEASE NOTE: If you are unable to make your lesson please inform BMFNT at least 1 hour before scheduled time. If you are 10 minutes late for your lesson time or you are a no show, you will still be required to pay for that lesson time.
_____ Initial to allow staff know you read and understand.

**** Would you be like to be included in Quarterly Newsletter Emails from BMFNT? (Circle) Yes/No**

Lessons are \$25.00 each for an hour and \$15.00 for a half hour. **A seasonal registration fee of \$30.00 must be enclosed for us to process this form. PLEASE MAKE ALL CHECKS PAYABLE TO BMFNT.**



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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT 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 BMFNT 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.

Client's Name: _____

Phone: _____ Address: _____

Zip: _____

In the event I cannot be reached, please contact:

(1): _____ Phone: _____

(2): _____ Phone: _____

Physician's Name: _____

Phone: _____

Preferred Medical Facility: _____

Health Insurance Co.: _____

Policy #: _____

___ **CONSENT PLAN** This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person listed below is unable to be reached.

Date: _____ Consent Signature: _____

Volunteer, parent, or guardian Print Name: _____

Phone: _____ Address: _____ Zip _____

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

Date: _____ Non-Consent Signature: _____

Volunteer, parent, or guardian Print Name: _____

Phone: _____ Address: _____ Zip _____



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PARENT OR STUDENT RELEASE

Name: _____ Date: _____

Address: _____ Zip: _____

Phone, Home: _____ Work: _____

Date of Birth: _____ Age: _____

Disability: _____ Date of Onset: _____

Height: _____ Weight: _____

Mother: _____ Father: _____

Guardian(s): _____

No student can be accepted for riding/on ground instruction until this form has been completed by the parent/parents and/or guardians. If the student is of legal age (21), he or she may complete the form without parent/parents or guardian(s) signature. Riding instruction will be under strict supervision and, although every effort will be made to avoid any accident, NO LIABILITY can be accepted by Big Maple Farm's Natural Therapies, Inc.

Physician's Name: _____ Address: _____
Zip: _____

Office Phone: _____

Physical Therapist and/or Occupational Therapist: _____
Address: _____ Zip: _____ Phone, Home: _____
Work: _____

I would like _____ to have riding/on ground instruction and I have discussed this with the student's doctor. I understand that NO LIABILITY can be accepted by Big Maple Farm's Natural Therapies, its officers, trustees, agents, employees, representatives, successors, or assigns.

SIGNATURE OF PARENT/PARENTS OR GUARDIAN(S):

SIGNATURE OF STUDENT OVER AGE 21:



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STUDENT MEDICAL HISTORY: TO BE COMPLETED BY A PHYSICIAN

NAME: _____ DATE: _____ PHONE: _____

Age: _____ Date of Birth: _____ Sex: _____ Height: _____

Weight: _____ Physically Handicapped: YES _____ NO _____

Developmentally Disabled: YES _____ NO _____

Emotionally Disturbed: YES _____ NO _____ Learning Disabled: YES _____ NO _____

DIAGNOSIS: _____

Cause: _____

Onset: _____

Limbs affected: _____

If spinal cord involvement, what vertebral level:

If Downs Syndrome, Atlanto-Axial subluxation? Yes _____ No _____
Cervical x-ray for Atlanto-Axial subluxation: Positive _____ Negative _____

Please indicate in graph if the student has any of the following secondary problems by checking yes or no. If yes, please include complete information pertaining to the problem.



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Problem	Yes	No	If yes, describe:
VISUAL			
HEARING			
SPEECH			
CARDIAC			Pulse: Blood Pressure:
CIRCULATORY			
Peripheral Vascular Dis.			
Hemophilia			
PULMONARY			
METABOLIC/GI GU			
Diabetes			
Bladder/Bowel Control			
SKIN/SOFT TISSUE			
Pressure Sore			Healed (yes/no) Location:
SURGERY			Date:
PAIN			
MEDICATION			
NEUROLOGICAL			
Seizures			Type: Controlled (yes/no) Last Seizure
Hydrocephalus			Shunt (yes/no)
Sensory Loss			
MUSCULAR			
Contractures			
SKELETAL			
Subluxing hips			
Dislocating hips			
Spinal Laminectomy			Degree, Type, Last X-ray
Scoliosis			Degree, Type
Kyphosis, Lordosis			
Spondylosis			
Spondylolisthesis			
Osteoporosis Heterotrophic Ossific.			
Arthrodesis			Healed (yes no) Location:
Fractures			



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OTHER or SPECIAL PRECAUTIONS

MOBILITY STATUS:

Can the student ambulate? Yes/No

Assistance: Independent _____ Minimal _____ Moderate _____ Maximal _____
1 person assist _____ 2 person assist _____

Physical aids: Canes _____ Crutches _____ Walker _____ Rolling Walker _____
Braces (type) _____
Other (i.e. splints) describe _____

Does the student use a wheelchair? Yes/No Type of w/c _____

Can the student propel the wheelchair? _____

Please describe any other additional information that might help us to work with this student. Thank you for your time.

Physician's Signature: _____ **M.D. Date** _____

Physician's Name (please print): _____

Phone: _____



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Physician's Authorization

Student's Name: _____

Phone: _____

Authorization for Therapeutic Horseback Riding. Authorization, where appropriate, for evaluation and treatment by a Physical, Occupational, and/or Speech Therapist.

Recommended Frequency:

1 time per week _____

2 times per week _____

3 times per week _____

4 times per week _____

5 times per week _____

Precautions:

Physician's Signature: _____ M.D.

Date: _____

Physician's Name (please print): _____

Address: _____ ZIP _____

Phone: _____

Physician's email (please print):



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THERAPY ASSESSMENT

Name _____ Age _____ Date _____

Disability: _____

Physical or Occupational Therapist: _____

Address: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Email (please print): _____

Evaluation Summary:

Goals:

Suggested Mounting Procedure:

Precautions and/or Restrictions:

Other comments:



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BARN RULES

1. Come into the session with a positive attitude and always remember to use a calm voice while around the animals!
2. Please be sure you have the proper foot ware! Hard soles are a must!
3. EVERYONE!!!!!!! Must wear a helmet while mounted on a horse.
4. Check the Bulletin board to see your assigned horse and volunteers.
5. Be Alert
6. Be relaxed
7. Do not enter the stalls without a volunteer.
8. Always wait for assistance.
9. Be sure to ask questions.
10. Do not bring the horse into the lesson area until the lesson ahead of you is complete.
11. Enjoy yourself and build a connection with the horse.
12. At the end of the lesson be sure to reward the horse with their treat from the buckets not your hands!!!!