Rider Registration Packet

Please fill out completely and return to:

The Therapeutic Equestrian Center

537 Northampton Street
Holyoke, MA 01040
413-532-1462
info@EquestrianTherapy.org
www.EquestrianTherapy.org

The Therapeutic Equestrian Center

Please Read and initial here ____

Policies and Registration Packet

The Therapeutic Equestrian Center (TEC) is a private 501(c)(3) non-profit organization whose mission is to provide equine-assisted activities and therapies for children and adults with special needs. In addition to therapeutic riding, our centers offer a number of therapeutic equine-related activities, including; competitions (horse shows, Special Olympics), ground work and stable management. More recently, programs offer services in human growth and development to serve wide-ranging audiences for such educational purposes as leadership training, team building and other human capacity enhancement skills for the workplace and for daily use.

- TEC would appreciate it if fees are paid in full at the beginning of the session, but if you choose to pay weekly the cost is $30 per lesson.
- We will invoice a third party if requested.
- Scholarships may be available for qualifying Holyoke residents.
- All Fees are nonrefundable.
- If TEC has to cancel, makeup sessions will be offered.
- We ask that all riders arrive on time for their lesson and ready to ride.
- We provide riding helmets for all riders.
- Long pants are required.
- Boots are encouraged.
- TEC follows the Holyoke School vacation and cancelation schedule
- To enroll in a session you must submit a completed application form. When the application is received TEC will try to find a suitable class and schedule the applicant. If a suitable group is not available your name will be put on a waiting list. You will be notified when an opening is available.
- Before the end of a session TEC would appreciate it if you would let us know if you wish to continue prior to the beginning of the next session. You may continue as long as you like but if you decide not to, we have a waiting list for available spots.

Therapeutic Equestrian Center
537 Northampton Street, Holyoke, MA 01040
413-532-1462 www.EquestrianTherapy.org

Participant's Application & Health History

GENERAL INFORMATION

Participant: ____

DOB: ________________ Age: _______ Height: _______ Weight: _______ Gender: M F

Address: ____

Phone: ________________ E-mail: ____________________ Alternative #: ________________

Employer/School: ____

Address: ____

Phone: ____

Parent/Legal Guardian: ____

Address (if different from above): ____

Phone: ____

HEALTH HISTORY

Diagnosis: ______________________________ Date of Onset: ________________

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

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

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, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

____
____
____
____
____
____

GOALS (i.e. why are you applying for participation? What would you like to accomplish?

____
____
____
____
____
____

Signature: ____ Date: ______________________

PHOTO RELEASE

I o DO

o DO NOT

consent to and authorize the use and reproduction by ______________________________________
(center)

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: ______________________

Client, Parent or Legal Guardian

Therapeutic Equestrian Center
537 Northampton Street
Holyoke, MA 01040
413-532-1462 www.EquestrianTherapy.org

Authorization for Emergency Medical Treatment Form

Name: ____ DOB: _____________ Phone: __________________

Address: ____

Allergies to medications: ____

Current medications: ____

In the event of an emergency contact:

Name: ____________________________________ Relation: ______________ Phone: _____________________

Name: ____________________________________ Relation: ______________ Phone: _____________________

Name: ____________________________________ Relation: ______________ Phone: _____________________

Consent Plan

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 ____Therapeutic Equestrian Center____________________________________ 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.

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

Consent Signature: ____ Date: __________________

Client, Parent or Legal Guardian

Liability Release

____ (*name*) would like to participate in the Therapeutic Equestrian Center's (TEC) program. I acknowledge the risks and potential risks of a horseback riding program. However, I feel that the benefits are greater than the risks assumed. I hereby, intending to be legally bound, waive and release forever all claims for damages against The Therapeutic Equestrian Center, its Board of Directors, Executive Director, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses sustained while participating in TEC's program.

Under Massachusetts law, an equine professional is not liable for injury to, or the death of, a participant in equine activities resulting from the inherent risk of equine activities pursuant to *Section 2D of Chapter 128* of the General Laws.

Signature: ____ Date: __________________

Client, Parent or Legal Guardian

Therapeutic Equestrian Center
537 Northampton Street
Holyoke, MA 01040
413-532-1462 www.EquestrianTherapy.org

Participant's Consent for Release of Information

I hereby authorize: ____
(person or facility)

to release information from the records of: ________________________________ DOB: _________________
(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:

- o Medical history
- o Physical therapy evaluation, assessment and program plan
- o Speech therapy evaluation, assessment and program plan
- o Mental health diagnosis and treatment plan
- o Individual Habilitation Plan (I.H.P.)
- o Classroom Individual Education Plan (I.E.P.)
- o Psychosocial evaluation, assessment and program plan
- o Cognitive-behavioral management plan
- o Other: ____

This release is valid for one year and can be revoked, in writing, at my request.

Signature: ____ Date: __________________________

Print Name: ____

Relation to Participant: _______________________________________

Please send materials to: ____

Please send materials to: ____

Therapeutic Equestrian Center
537 Northampton Street
Holyoke, MA 01040
413-532-1462 www.EquestrianTherapy.org

Date: ________________________________

Dear Health Care Provider:

Your patient, ____
(participant's name)

is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability - include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia

Other

Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - i.e. Photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Participant's Medical History & Physician's Statement

Participant: ____ DOB: ________ Height: _______ Weight: ______

Address: ____

Diagnosis: ____ Date of Onset: _________________

Past/Prospective Surgeries: ____

Medications: ____

Seizure Type: ___________________________________ Controlled: Y N Date of Last Seizure: ____________

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: AtlantoDens Interval X-rays, date: ________________ Result: + —

Neurologic Symptoms of Atlanto Axial Instability: ____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that the PathIntl center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the Therapeutic Equestrian Center for ongoing evaluation to determine eligibility for participation.

Name/Title: ____ MD DO NP PA Other __________

Signature: ____ Date: ______________________

Address: ____

Phone: (_____) ______________________________ License/UPIN Number: ______________________________

Client Intake Form

Agency: ____Therapeutic Equestrian Center__________________ Date: ____________

Client Name: ____

Address: ____

Female Head of Household: Yes _____ No _____

Disabled: Yes _____ No _____

Hispanic: Yes _____ No _____

Race (must circle one): White Black Asian American Indian Pacific Islander Other/Mixed

Income: You must circle how many people are in your household AND circle your household income under that column

Household Size	1 Person	2 Persons	3 Persons	4 Persons	5 Persons	6 Persons	7 Persons	8+ Persons
< 30% Very Low	$18,050 or below	$20,600 or below	$23,200 or below	$25,750 or below	$27,850 or below	$29,900 or below	$31,950 or below	$34,000 or below
< 50% Low	$30,100 or below	$34,400 or below	$38,700 or below	$42,950 or below	$46,400 or below	$48,850 or below	$53,300 or below	$56,700 or below
< 80% Moderate	$44,750 or below	$51,150 or below	$57,550 or below	$63,900 or below	$69,050 or below	$74,150 or below	$79,250 or below	$84,350 or below
Over 80%	$44,751 or higher	$51,151 or higher	$57,551 or higher	$63,901 or higher	$69,051 or higher	$74,151 or higher	$79,251 or higher	$84,351 or higher

Signatures are required

I certify that all the information on this form is true and correct and that all income is reported. I understand this information is being given for the receipt of federal funds, that the information on this application may be verified, and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws. I also understand that this information will NOT be released to unauthorized persons.

____ ________ ____________________________________ _______

Client Signature Date Staff Signature Date

Please Note

Due to our monitoring requirements with HUD if this form is incomplete it will not be entered as a new client

Thank You

Cliente Formulario de Admission

Agencia: ___Therapeutic Equestrian Center___________ Fecha: _____________

Nombre de Cliente: ____

Direccion: ____

Numero de Personas en el Hogar: _______

Jefe de Familia Femenino: Si ______ No _______

Hispano: Si _____ No ______

Incapacidad: Si ______ No _____

Raza (circule uno): Blanco Asiatico Indio Americano Isleno del Pacifico Otro/Mixto

Debe circular cuantas son las personas de su familia Y
Circule con los ingreso de los hogares en la columna

Tamano de Familia	1 Persona	2 Personas	3 Personas	4 Personas	5 Personas	6 Personas	7 Personas	8+ Personas
< 30% Muy Baja	$18,050 o inferior	$20,600 o inferior	$23,200 o inferior	$25,750 o inferior	$27,850 o inferior	$29,900 o inferior	$31,950 o inferior	$34,000 o inferior
< 50% Baja	$30,100 o inferior	$34,400 o inferior	$38,700 o inferior	$42,950 o inferior	$46,400 o inferior	$48,850 o inferior	$53,300 o inferior	$56,700 o inferior
< 80% Moderado	$44,750 o inferior	$51,150 o inferior	$57,550 o inferior	$63,900 o inferior	$69,050 o inferior	$74,150 o inferior	$79,250 o inferior	$84,350 o inferior
En 80%	$44,751 o superior	$51,151 o superior	$57,551 o superior	$63,901 o superior	$69,051 o superior	$74,151 o superior	$79,251 o superior	$84,351 o superior

Frimas Requerida

Yo certifico que toda informacion en este formulario esta y es verdadera y que todo ingreso esta reportado. Yo entiendo que esta informacion es dada para recibir fondos federales, y que esta informacion puede ser verificada, y que la falsificacion deliberada de la informacion me puede haver sujeto a persecucion bajo las leyes estatales y federales. Yo tambien entiendo que la information NO sera divulgada a personas no autorizadas.

_____________________________ __________ ____ _________

Firma del Cliente Fecha Firma del Personal Fecha

FOR FAVOR TENGA EN CUENTA
Debido a requisitos de monitoreo con HUD si este formulario está incompleto, no se introduce como un nuevo cliente
Gracias