Discovery Riders, Inc.
P.O. Box 217 * Bellefontaine, Ohio 43311 * 937-935-6545

Year: _____
Session: _____

Participant's Application and Health History

(Must be returned at least 2 weeks prior to the first class)

GENERAL INFORMATION

Participant:_____

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

Diagnosis:_____ Secondary Diagnosis: _____

Address:_____

Phone #:_____ Alternative #:_____

Employer/School:_____

Address:_____Phone#:_____

Parent/Legal Guardian:_____

Address (if different from above):_____

Phone#:_____Email:_____

How would you prefer to be contacted? (Email, texting, calling, all three?)_____

Referral Source:_____

Contact Numbers:_____

How did you hear about the program?_____

What days would you prefer for class? (circle) Mon Tues Wed Thur Fri Sat - underneath put 1st, 2nd, 3rd choices

PHOTO RELEASE

- ❑ I DO
- ❑ I DO NOT

Consent to and authorize the use and reproduction by Discovery Riders, Inc. 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

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Health History

Please indicate current or past problems in the following areas:

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

What medications are you currently taking, frequency, administration times including over-the-counter medications?_____

_____

_____

_____

Is there a history of seizures? _____ If so, type _____Date/Last seizure _____

Warning signs: _____

_____

(Continued)

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

FUNCTION (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

_____

_____

_____

_____

_____

SOCIAL (i.e. Work/school including grade completed, leisure interests, relationships- family structure, support systems, companion animals, fears/concerns, etc)

_____

_____

_____

_____

_____

Horse Experience (i.e. Have they ever been around horses? How many years? Type?)

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

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AUTHORIZATION for EMERGENCY MEDICAL TREATMENT FORM

☐Participant ☐Staff ☐Volunteer

Name:_____ DOB:_____ Phone:_____

Address:_____

Physician's Name:_____ 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 Discovery Riders, Inc. 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: The 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

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PERMISSION TO PARTICIPATE IN DISCOVERY RIDERS' THERAPEUTIC RIDING PROGRAM, DISCLOSURE, RELEASE OF CLAIMS, CONSENT TO EMERGENCY MEDICAL TREATMENT AND INDEMNIFICATION

I, _____("Participant"), have chosen to participate in the Discovery Riders Therapeutic Riding Program ("Program") and its related horse activities. I _____ (parent or guardian) have chosen to allow Participant to participate in Program.

I am aware that:

A. Horses have a tendency to behave in ways, which may result in injury, death, or loss to riders, or other persons in the immediate vicinity;
B. Horses may react in an unpredictable way to sounds, sudden movement, unfamiliar objects, persons, or other animals;
C. Riding a horse may give rise to a risk of injury from hazards arising from the surface or subsurface of the ground in which these riding activities occur;
D. While in the vicinity of a horse or while riding a horse, I may be involved in a collision with another horse, another animal, a person, or an object;
E. Other individuals in the program may fail to maintain control over a horse or fail to act within their abilities, thus causing harm to me or other individuals; and
F. Other individuals in the program may act in a negligent manner, which could result in harm to me.

As parent or guardian I have discussed with individual the need to behave in a safe manner. I will make sure that individual wears appropriate clothing and footwear during horse activities and other program activities.

In consideration for the opportunity to participate in Program activities and the use of services and facilities made available through these Program activities, I do release and forever discharge for myself and my heirs, executors, administrators, and assigns, and for individual and individual's heirs, executors, administrators and assigns, the leaders, agents, employees, volunteers, directors, officers, administrators, faculty and staff, of Discovery Riders, from all claims, demands, and causes of action for personal injury or any other damage which may arise out of or be in any way related to individual's participation in Program.

I grant individual permission to participate in Program and its related horse activities despite the possible risks. I recognize that by participating in these activities, as with any physical activity, individual may risk personal injury. I hereby attest and verify that I have been advised of the potential risks, that I have full knowledge of the risks involved in these activities, and that I assume any expense that may be incurred in the event of an accident, illness, or other incapacity, regardless of whether I have authorized such expenses. As a parent/guardian, I assume the same risk for myself, and other family members and friends present at these Program activities.

In the event of emergency or injury to individual requiring immediate medical attention for individual , I hereby consent to emergency medical treatment, including transportation to medical providers, for individual .

I agree to indemnify and hold harmless Discovery Riders for any claims, damages, or causes of action arising from individual's conduct and/or participation in Program.

Signed_____ Dated_____ Signed_____ Dated_____

(Parent or Guardian)

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FINANCIAL AGREEMENT

Each Therapeutic Riding Session is 10 weeks long, one hour per week. The cost is $400 for each 10-week session payable the first class of each session, unless other arrangements are made. A minimum of $40 is required at the start of each session.

Please indicate any funding source that is available to the class participant:

County: Agency:

Agency Contact: Phone:

Billing Address: City State Zip

Private scholarship: Donor Name:

Phone:

Billing address: City State Zip

School Grant: Name of School:

School Contact: Phone:

Billing Address: City State Zip

Families of the class participants are responsible for session costs. The costs of the Therapeutic Riding classes are not reimbursable by insurance companies.

Please indicate where you would like the session invoice to be sent and to whose attention: if your billing information is other than yourself.

_____

_____

_____

_____

Participant Name _____ Date_____

Signature _____Relationship_____

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Scholarship Application

Participant's Name: _____ Age: _____ Phone (h): _____ Email: _____

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

Mother/Guardian: _____ Phone (h): _____ (w): _____ Employer: _____

Father/Guardian: _____ Phone (h): _____ (w): _____ Employer: _____

Status (check one): Single ☐ Married ☐ Divorced ☐ Other ☐

Financial assistance is granted based on documented financial need and to the extent funds are available. These scholarships are made possible by support. Assistance will be awarded without regard to ethnicity, creed, religion, disability or nationality. All information will be kept confidential. In the chart below please circle the number of persons in your household; circle the applicable income limit listed under that household size. Total yearly income includes all sources of income for all members residing in the home. **EXAMPLE:** If your household consists of two (2) people and your total yearly income is $32,000, you would circle 2 persons and Row (3) Equal or less than $32,920.

Therapeutic Riding Program Fees (based on a 10 - week session) Total $400.00

Therapeutic Riding Program

Number in Household	1 Persons	2 Persons	3 Persons	4 Persons	5 Persons	6 Persons	PER 10 WEEK SESSION
Equal to or Less than	$12,140	$16,460	$20780	$25,100	$29,420	$33,740	90% SCHOLARSHIP = $40.00
Equal to or Less than	$15,175	$20,575	$25,975	$31,375	$36,775	$42,175	70% SCHOLARSHIP = $120.00
Equal to or Less than	$24,280	$32,920	$41,560	$50,200	$58,840	$67,480	20% SCHOLARSHIP = $320.00

Participants awarded a scholarship are eligible to receive one (1) scholarship per family covering up to four 10-week sessions. Scholarships are applied for at the beginning of each new year. Attendance and participation will affect the eligibility of scholarships.

ALL INFORMATION FURNISHED HEREIN IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE:

Parent/Guardian Signature: _____Date:_____

Attach copies of your most current Federal Tax Return showing Adjusted Gross Income to this application in order to qualify.

If you need financial assistance and do not qualify according to the above income levels, please send us a letter indicating why you should receive financial assistance along with the above-mentioned forms.

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CODE OF CONDUCT

It is essential to Discovery Riders to have a Code of Ethics and Conduct that will serve as a guide to proper conduct of all volunteers, staff and participants. We expect everyone to observe the highest standards in ethics and integrity in their conduct. This means following the basic code of conduct including the following.

1. In order to protect all our staff, volunteers and clients – at no time during an event may staff or volunteers be alone with a single child where staff or the volunteer cannot be observed by others. Staff and volunteers shall never leave a child unsupervised. Only parents/guardians or caretakers are to assist a client in the restroom. Under no circumstances should staff and volunteers release children to anyone other than the authorized parent, guardian or other adult authorized by the parent or guardian (written parent authorization on file with Discovery Riders). Discovery Riders staff and volunteers are not to transport participants.

2. Staff and volunteers must use positive techniques of guidance, including redirection, positive reinforcement and encouragement rather than competition, comparison and criticism. Staff will have appropriate expectations and set up environments that minimize the need for discipline. Physical restraint is used only in pre-determined situations (necessary to protect the client or other clients from harm), is only administered in a prescribed manner, and must be documented in an incident report.

3. Staff and volunteers will respond to clients with respect and consideration, and treat all clients equally regardless of sex, race, religion or culture. Staff and volunteers will respect children's rights to not be touched in ways that make them feel uncomfortable, and their right to say no. Any type of abuse will not be tolerated and may be cause for immediate dismissal.

4. Discovery Riders' staff, volunteers, participants and their families will work to maintain a positive attitude, one of respect, patience, courtesy, tact and maturity. While enjoying equine assisted activities at the Center.

5. Staff and volunteers must appear clean, neat and follow the dress code policy.

6. Using, possessing or being under the influence of alcohol or illegal drugs is prohibited. Smoking or the use of tobacco is prohibited.

7. Profanity, inappropriate jokes, sharing inappropriate details of one's personal life and any kind of harassment will not be tolerated.

8. Volunteers or staff members may receive information regarding the participants. The staff and volunteers will treat any information regarding the participant as confidential.

9. No one handling an equine or participating in an activity with an equine may use their cell phone.

I understand that any violation of this Code of Conduct may result in termination.

_____ _____

Signature Date

Discovery Riders, Inc.
P.O. Box 217 * Bellefontaine, Ohio 43311 * 937-935-6545

Dear Physician: _____ Date:_____

Your patient_____ (participant's name) is interested:

_____ Supervised equestrian activities
_____ Therapeutic horseback riding lessons
_____Hippo therapy with a licensed Physical, Occupational, or Speech Therapist

In order to safely provide this service, we request 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 therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

ORTHOPEDIC

Atlantoaxial Instability
– include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint Subluxation/Dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

NEUROLOGIC

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/
-Tethered cord/Hydromyelia

MEDICAL/PSYCHOLOGICAL

Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medial conditions
Fears
Heart Conditions
Hemophilia
Medical instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Weight Control Disorder

OTHER

Indwelling Catheters Medications – i.e. photosensitivity Skin Breakdown

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact us.

Sincerely
Director 937-935-6545

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Participant's Medical History & Physician's Statement

Participant:_____ DOB:_____
Address: _____
Diagnosis:_____Date of Onset:_____
Height:_____ Weight:_____Past/ProspectiveSurgeries:_____
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:_____

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			
Pain			
Other			

***Down Syndrome**:* Annual Physical Exam by a Physician for Symptoms of Neurologic Symptoms of AAT or Focal Neurologic disorder: ☐ Present ☐ Absent

Physician's Signature: _____ Date: _____

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 PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

Name/Title:_____ MD DO NP PA Other
Signature:_____Date:_____
Address:_____
Phone: (_____)_____ License/UPIN Number:_____

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Student Guidelines/Barn Rules

1. The student must be **FOUR** years of age and have a minimum sitting balance and head control of a 6-month-old. Students who have had a Gran Mal seizure within the last year may not be eligible for horseback riding.
2. Weight limits are dependent on our ability to safely ride the individual. Considerations horse availability, and client's level of assistance needed while mounted are taken into account.
3. All students with Down syndrome **MUST** be examined by a physician for symptoms of Atlantoaxail Dislocation Condition (ADC). We are not permitted to ride anyone with symptoms of ADC.
4. **ALL FORMS MUST BE FILLED OUT, SIGNED AND RETURNED** to us before the student may ride. No student will be permitted to ride without these forms.
5. When riding, the student must be in long pants and a sturdy shoe, preferably with heels. **SANDALS ARE NOT PERMITTED,** and shorts are discouraged due to the risk of pressure sores. Approved helmets are required and provided. Please remember to wear hair styles that are conducive to a snug-fitting hard hat. Avoid dangling earrings and other jewelry.
6. Please observe all barn rules while at the farm. All family and visitors should stay inside the viewing area unless specifically invited to go to another part of the building.
7. Our volunteers give of their time and talent so that you are able to ride. **PLEASE** let us know **AS SOON AS POSSIBLE** if you will be unable to attend class so that we can schedule our volunteers accordingly. Call or text 937-935-6545.

It is very rare for us to cancel class, but you will be notified as soon as possible should it be necessary. Please listen to your local radio stations in case of very bad weather.

8. **TWO UNEXCUSED ABSENCES WILL CAUSE YOU TO BE EXCUSED FROM THE PROGRAM**.
9. If we determine that this type of riding therapy is not suitable for a student because of safety to the student, volunteer, instructor, horse, or for any other reason, we reserve the right to deny riding to that student.
10. All class fees are subsidized up to 40% by Discovery Riders (donations and grants). Therefore, we will not make up lessons. (See Payment Policy)
11. Discovery Riders is an inclusive environment where everyone is treated with kindness and respect. You may be asked to leave the facility if you participate in rude, un-kind or harmful behavior.
12. We are a NO SMOKING FACILITY. There is no smoking anywhere on the property.
13. The use of a cell phone is prohibited while handling, riding a horse or while participating in an equine assisted activity.

BARN RULES

1. All participants must wear a helmet when in the arena or working with an equine.
2. No running, yelling, jumping, or screaming in the barn or observation room. "Horsing around" can be harmful.
3. Everyone should walk around the horse with a hand on the horse or at an appropriate distance away. Do not walk under the horse's neck. No kneeling or bending over while near a horse.
4. All treats must be fed using a treat bowl.
5. Close-toed shoes must be worn working with the horses. No flip flops, crocs, or slip on shoes that easily come off.
6. Students must be with an instructor or volunteer when leaving the waiting area.
7. No chewing gum while mounted.
8. Never wrap a lead attached to a horse around any part of your body. Always tie the horse to tie rings using a safety knot.
9. Treat all riders, volunteers, staff, and animals with dignity and respect.
10. There is no smoking or solicitation at Discovery Riders. Smoking is prohibited anywhere on the property.

Thank you for your cooperation the Discovery Riders Staff