WELCOME TO CAMP!

Thank you for choosing Wylde Horses Therapeutic Riding Facility! We are excited to welcome your child (and you!) to a fun, enriching, and safe experience filled with horsemanship, nature, and creativity.

Our mission is to create a space where individuals of all abilities can build confidence, skills, and joy through therapeutic interaction with horses and the natural world.

These camps are open to **everyone in the community**, not just Wylde Horses participants. Our program is **inclusive,** welcoming **all ages and abilities**.

Parents, guardians, or caretakers are more than welcome to stay and attended, however, it is not required. If you feel the participant would thrive better with your attendance, we encourage it!

CAMP SCHEDULE

Our camps are held **one Saturday per month from 9:00 AM to 12:00 PM**.

WHAT TO EXPECT

Our camp program is designed around a rotating schedule of fun and therapeutic stations. **Core activities** will change and circulate each season and will be announced at our earliest convenience.

Core Activities Include:

- Horsemanship
- Animal Interactions
- Arts & Crafts
- Gardening & Nature Exploration

WHAT TO BRING

- Refillable water bottle
- Closed-toe shoes
- Comfortable, weather-appropriate clothing
- Sunscreen & hat
- Any necessary medications (with instructions)
- Preferred snack if desired

Note: Snacks and water will be provided half way through camp

Contact Information

Participant: _____

Date of Birth: _____ Gender: M F Weight: _____ Height:_____

Current Diagnosis: _____

Current Treatment/Services: _____

Participant is a (circle one): Minor Adult with legal guardian Independent adult

Street Address: _____

City: _____ State: _____ Zip Code: _____

Parent-Guardian/Primary Contact: _____

Phone: _____

Email Address: _____

Parent-Guardian/Secondary Contact: _____

Phone: _____

Email Address: _____

School or Educational Facility presently attending: _____

In case of emergency (other than parent or guardian listed above)

Contact #1: _____

Phone: _____

Is the participant a client of San Diego Regional Center? Yes No

SDRC Coordinator First and Last Name: _____

Phone Number: _____

Email: _____

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WYLDE
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Health History

Primary Diagnosis: _____

Secondary Diagnosis: _____

**Please note: Before riding, participants with a diagnosis of Down Syndrome will be required to provide a doctor's note verifying they are negative on neurological exam for any decrease in neurological function, or of any symptoms consistent with Antlantoaxial Instability.*

Does the participant …	**YES**	**NO**	**Comments**
Walk Independently?			
Have poor balance sibling/standing balance?			
Use wheelchair, walker, braces, orthotics?			
Any other medical equipment/devices?			
Have speech/language difficulties?			
Have problems with fine motor skills?			
Have problems with gross motor skills?			
Have asthma or breathing problems?			
Have any allergies? I.e. Hay, horses, peanut butter			
Have pain?			
Have emotional/behavior problems?			
Have heart/circulation issues?			
Have short/long term memory loss?			
Have any current or past seizure history?			
Have any hearing difficulties?			
Have any sensory issues?			
Have a fear of heights?			
Have a fear of animals/horses?			

**Please feel free to write below with any details on the above items. Or you can attach additional information to give more insight on the above conditions. Medical reports are also very helpful*

_____

_____

_____

_____

_____

_____

Questionaire

Has the participant had any previous experience with therapeutic riding or horses? Yes No

If yes, please explain?

Goals: What are you hoping to accomplish by participating at Wylde Horses?

Comments: Please give any info that you feel will be helpful in lesson planning

Please check any of the following that applies:

- o Depressed mood
- o Anxious mood
- o Excessive worrying
- o Impulsivity
- o Fatigue
- o Loss of interest
- o Sleep difficulties
- o Racing thoughts
- o Loss of appetite
- o Excess energy
- o Low self-esteem
- o Non-Verbal
- o Grief/Loss
- o Comfort eating
- o Poor concentration/focus
- o Relationship stress
- o Drug/Alcohol abuse
- o Difficulty w/ self-expression
- o Aggressive behavior

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Seizure Information

Does the participant have seizures? Yes No

If yes, please fill out the following form.

What may cause the seizures?

On average, how often do they occur?

Are there any warning signs before a seizure starts?

What is the average duration of a seizure?

How does the participant feel and behave after a seizure? How long does this last?

How would you like us to handle the situation, should a seizure occur while riding?

Is there anything else that we need to know about the seizures?

Rider Authorization for Emergency Medical Treatment

In the event emergency treatment/medical aid is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Wylde Horses facility 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: _____
Clients Phone #: _____
Clients Address: _____
Allergies: _____

In the event I cannot be reached:
Contact #1: _____
Phone Number: _____
Contact #2: _____
Phone Number: _____

Physicians Name: _____
Preferred Medical Facility: _____
Health Insurance Company: _____
Policy Number: _____

Please choose one of the following

Consent Plan
This authorization includes x-rays, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by a physician. This provision will only be invoked if the person is unable to be reached.

Date: _____ Consent Signature: _____
(Client, Parent, or Guardian)
Print Name: _____
Phone: _____
Address: _____

Non-Consent Plan
I do not give my consent of 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 agency. In the event of emergency treatment/aid if required, I wish the following procedures to take place:

_____
_____
_____

Date: _____ Non-Consent Signature: _____
(Client, Parent, or Guardian)
Print Name: _____
Phone: _____
Address: _____

SIGN-UP & RESERVATIONS

All participants must register in advance to secure a spot. Space is limited and filled on a first- come, first-served basis. Once this form is completed and returned, **YOUR SPOT WILL BE CONSIDERED RESERVED.**

Participant Fee: $450 per camper

Cancellation Policy:

- If you cancel **at least one week** prior to the scheduled camp date, we will reschedule or cancel your reservation at **no charge**.
- If you cancel **within one week of camp**, the responsible party will still be **charged the full camp amount**.
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IMPORTANT FOR PARTICIPANTS IN SAN DIEGO REGIONAL CENTER:

If your child receives services through the San Diego Regional Center, your **case coordinator must be notified** of the scheduled camp date to **authorize attendance** and ensure payment can be arranged through CIS. Please feel free to authorize as many dates as you'd like to attend as far in advance as possible.

Please note, just because you authorize for future camps, does not mean you are reserved and responsible to show up. This is an easy way to stay ahead of the game if you do choose to attend. If you decide not to reserve a spot, CIS will not be billed.

SAFETY & PARTICIPANT WAIVER

At Wylde Horses Therapeutic Riding Facility, we strive to create a safe and nurturing environment. However, it is important to acknowledge the inherent risks involved in equine and outdoor activities.

By signing below, you acknowledge and agree to the following:

1. I understand that participation in horseback riding and related activities involves **inherent risks**, including but not limited to falls, animal behavior, weather conditions, and uneven terrain.
2. I acknowledge that **serious injury or death** may result from participation in equine activities.
3. I voluntarily assume all risks associated with participation in camp activities at Wylde Horses Therapeutic Riding Facility.
4. I agree to **hold harmless Wylde Horses Therapeutic Riding Facility, its staff, volunteers, board members, and property owners** from any and all liability, claims, demands, causes of action, or expenses resulting from participation.
5. I confirm that my child (and myself, if staying onsite) is physically and emotionally capable of participating in the described activities.
6. I grant permission for Wylde Horses to seek emergency medical treatment for myself or my child if necessary.

PARTICIPANT INFORMATION & SIGNATURES
Participant Name: _____

Parent/Guardian Name: _____

Emergency Contact Number: _____

Medical Conditions/Allergies: _____

Signature of Participant (if over 18): _____

Date: _____

Signature of Parent/Guardian: _____

Date: _____

If Parent/Guardian is staying onsite:

Signature of Attending Adult: _____

Date: _____