Reins To Recovery, Inc.
Therapeutic RIDING CENTER
10861 N. US 31
Seymour, IN 47274
Tel: (812) 350-4864 Barn: (812) 445-4050
Fax: (812) 445-4051
E-Mail: reinstorecovery@gmail.com
Mailing Address: PO Box 1492 Columbus IN 47202

CLIENT/RIDER APPLICATION

Client Information Today's Date:_____

Client's name: _____

Preferred name: _____ Gender: M ____ F____

DOB: _____

Parent/Legal guardian names:

_____ _____

Address to which all mailings should be sent: Parent/legal guardian address/phone if different:

Street _____ Street _____

Town _____ Town _____

State_____ Zip code_____ State _____ Zip code_____

(C*ounty*)_____ (C*ounty*)_____

Home phone:_____ Home phone:_____

Cell phone: _____ Cell phone:_____

Work phone:_____ Work phone:_____

Email: _____ Email:_____

Fax number: _____ Fax number: _____

Group home name (*if applicable*):_____

Group home phone and supervisor name: _____

Contact phone number for lesson cancellations, etc:
1.) _____ 2.) _____

CLIENT LIABILITY RELEASE

Indiana State Equine Laws state that: Under Indiana Law, an 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.
_____ (Clients name) would like to participate in the Reins To Recovery, Inc. Therapeutic Riding Center program(s). I acknowledge the risks and potential for risks of engaging in horseback riding activities as well as activities in close proximity to horses. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors and/or administrators, waive and release forever all claims for damages against Reins To Recovery, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers, Employees, Stable Owners, and/or Stable Employees, for any and all injuries and/or losses that I/my so/ my daughter/ my ward may sustain while participating in activities at Reins To Recovery, Inc. Therapeutic Riding Center.

Print name: _____Date: _____

Client/Legal guardian consent signature:_____

I hereby ☐ **consent** to and authorize *or* ☐ **do not consent** to or authorize the use and reproduction of any and all photographs and any other audiovisual materials taken of me/my son/ my daughter/ my ward by Reins To Recovery, Inc. Therapeutic Riding Center for promotional printed material, educational activities, media, website, and exhibitions, or for any other use for benefit of the Reins To Recovery program.

Client/Legal guardian signature:_____

Date: _____

How did you hear about the program(s) at Reins To Recovery, Inc. Therapeutic Riding Center? Please list the name of the person or source.

Friend: _____

School/Teacher:_____

Doctor: _____

Newspaper/magazine: _____

Other (please specify): _____

RIDER/CLIENT INFORMATION

This information may be used by Reins To Recovery, Inc. staff to assist in lesson planning for therapeutic riding clients. Please complete this form to the best of your knowledge.

Name:_____ Age: _____

Today's Date:_____

Rider/client grade in school or educational level: _____

School or employer:_____

Personality Profile

Please describe the rider/clients' personality: _____

_____

_____

_____

List the rider/clients' favorite activities, preferences? _____

_____

_____

List any rider/client fears or dislikes? _____

_____

_____

Cognitive Skills (does not apply if all cognitive skills are within normal limits). Check the box if the rider/client know/understand the following: (explain below if needed)

Educational/Cognitive	Social	Language
❑ Knows numbers	❑ Recognizes name	❑ Makes sounds/gestures
❑ Knows letters	❑ Knows "NO"	❑ Says words
❑ Knows left and right	❑ Makes eye contact	❑ Combines two or more words
❑ Knows prepositions	❑ Waves/says hello/bye	❑ Speaks in complete sentences
❑ Describes feelings	❑ Shares toys/items	❑ Understands simple concepts
❑ Makes choices	❑ Understands rules	❑ Understand complex concepts
❑ Follows 1 step direction	❑ Appropriate touching	❑ Sounds out words
❑ Multi step directions	❑ Interacts with peers	❑ Recognizes sight words
❑ Good problem solving	❑ Appropriate conversation	❑ Reads sentences

Rider/client communicates: ____verbally, ____ with assistive device, ____ sign language, ____ picture icons, ____gestures, and ____ sounds.

Physical Skills

Check the box if the rider/client do the following: (Explain below if needed

❑Roll over	❑Weight bearing on hands	❑Push a walking toy
❑Sit unassisted	❑Hold object	❑Feeds self
❑Crawl	❑Release object	❑Dresses self
❑Stand	❑Catch a ball	❑Kick a ball
❑Walk	❑Open doors/container	❑Plays on swing
❑Run	❑Uses utensils	❑Jump rope
❑Climb stairs	❑Use hands independently	❑Swim
❑Stand on one foot	❑Manipulates fasteners	❑Ride a bike (tricycle)
❑Hop/jump	❑Holds pencil/crayon/pen	❑Plays sports
❑Skip	❑Writes legibly	❑Drives a car/motorcycle

Assistive Devices

Please list any devices that the rider/client may use at home or school:
Wheelchair: Power Manual_____
Stroller: _____
Walker: _____
Crutches/braces:_____
Stander:_____
Gait trainer: _____
Orthotics: _____
Splints: _____
Prosthetics: _____
Cervical collar, TLSO, abdominal binder, other trunk support
Other assistive devices: _____

Client/Family Goals

Reins To Recovery, Inc. is a center striving to provide the highest quality adaptive riding instruction for our riders and clients. Thank you for taking the time to help us provide the best possible services.

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Dear Health Care Provider:
Your patient is interested in participating in equine related activities at the Reins To Recovery, Inc. Therapeutic Riding Center. In order to safely provide this service, our center requests you to complete the attached "Annual Medical History and Physician's Statement".
The North American Riding for the Handicapped Association (NARHA) has written guidelines for NARHA centers pertaining to precautions and contraindications for individuals participating in equine related activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree. The following is a list of suggested precautions and contraindications:

Orthopedic:
Atlantoaxial Instability
Coxa Arthrosis
Cranial Deficits
Heterotopic
Ossification/Myositis Ossoficans
Joint Subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities
Neurologic:
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II
Malformation/Tethered
Cord/Hydromyelia
Other:
Age- under 2 years
Indwelling Catheters
Medications – i.e. photosensitivity
Poor endurance
Skin Breakdown
Medical/Psychological:
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought control disorders
Weight control disorders

Precautions and Contraindications in Equine Assisted Activities

The primary focus of any therapeutic riding facility is providing a safe and productive experience for all participants. The question that must be asked is "Will the benefit of the equine activity outweigh the risk?" The general rule is "do no harm".
A precaution is defined as a measure taken beforehand against possible danger, failure, etc. Participants with precautions may require modifications of the program, additional equipment, and always require re-evaluations at regular intervals to assure the appropriateness of the program.
A contraindication is a condition or symptom that makes equine related activities inappropriate. Few contraindications are clear-cut. A contraindication may be permanent; meaning some activities may never be appropriate for certain participants due to safety or health concerns. A contraindication may also be temporary until the participant's health or condition improves. A participant may also begin in equine related activities but may find it no longer safe to participate with the progression of his or her disability.

The following must be considered when deciding to accept a participant into a NARHA center:

* Most equine activity inherently involves movement. If the movement will cause a decrease in the participant's function, an increase in pain or generally aggravate the medical condition it may not be the activity of choice.
* The essence of equine activities is the human-animal connection. If this interaction is detrimental to the participant, or the equine, equine activities may be contraindicated.
* Horseback riding or driving always presents the potential for a fall. Such a fall may cause a greater functional impairment than the participant originally had. The possibility of a fall should be given careful consideration, and may lead to the informed decision that mounted or driving activities are not the activity of choice.
* Working around equines (i.e. grooming, leading, etc.) involves risk. Even the well-trained equine is subject to its instinctive fight or flight responses. Horses are large, move quickly and can be dangerous to the participant who is unable to respond appropriately.

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ANNUAL MEDICAL HISTORY and PHYSICIAN'S STATEMENT

Please have the following information completed by the client's physician. The physician's signature of consent is required. This information is kept confidential.

Client Information

Client's name: _____ Today's Date: _____

Address: _____

DOB: _____Gender: M ____ F ____

Height: _____Weight: _____ *Physician's initials are required here* ____

*It is crucial that this information be truthful and accurate. To provide inaccurate information may jeopardize the safety of the rider and others.

Medical Summary

Primary diagnosis: _____

Cause if known: _____

Other diagnoses: _____

If Down Syndrome, date of and result of test for AAI: _____

_____

Recent surgical procedures or hospitalization: _____

_____

Brief current medical condition:_____

_____

Date of last tetanus: _____

Current Medications

Name: _____ Dose: _____For treatment of:_____

Name: _____ Dose: _____For treatment of:_____

Name: _____ Dose: _____For treatment of:_____

Name: _____ Dose: _____For treatment of:_____

Name:_____ Dose: _____ For treatment of: _____

Abilities

Assistive Aids (please check all that currently apply to the client, or note history in space provided):

_____ Orthotics/Splints/Prosthetics (specify type): _____

_____

_____ Cervical collar/Abdominal binder/Other trunk supports (specify type):_____

_____

_____ Wheelchair/Walker/Crutches (specify type): _____ **7**
_____ Other assistive aids:_____

Physical Skills (Please rate the following skills using the scale provided): Explain if needed. Does the rider need assistance, if so what kind?
(0) Not able to perform (1) Beginning skill (2) Moderate ability (3) Mastered skill

_____ Head and neck control_____
_____ Unsupported sitting balance _____
_____ Unsupported standing balance _____
_____ Unsupported walking _____
_____ Upper extremity (arm) strength /movement _____
_____ Lower extremity (leg) strength /movement_____
_____ Fine motor (hand/finger) strength /movement _____
_____ Gross motor (whole body) coordination _____

Cognitive Skills (Please rate the following skills using the scale provided): Explain if needed. Does the rider need assistance, if so what kind?
(0) Not able to perform (1) Beginning skill (2) Moderate ability (3) Mastered skill
_____ Alertness/Attention _____
_____ Ability to follow 1-step commands _____
_____ Ability to follow multiple-step commands _____
_____ Activity level /endurance _____
_____ Visual ability _____
_____ Expressive Language _____
_____ Language Comprehension _____
_____ Socialization skills _____

Precautions/Contraindications (Please check and/or circle all that currently apply to the client and degree of involvement, or note history in space provided. Please note that the following conditions may be contraindicative to horseback riding):
____ Allergies (specify Type) _____
____ Arthritis (rheumatoid or osteo)_____
____ Asthma _____
____ Atlanto-axial instability (recent X-ray date and results)
_____
____ Behaviors _____
____ Blood clots, deep vein thrombosis, peripheral vascular disease_____
____ Body temperature regulation problems _____
____ Bone abnormalities (osteoporosis, pathologic fractures)
_____
____ Brain injury_____
____ Communicable Diseases _____
____ Contractures/limited ROM (location?)_____
____ Gastro-intestinal or naso-gastric or tracheal tube _____
____ Heart condition/abnormality _____
____ Hypertension _____
____ Joint/tendon laxity, subluxation, dislocation _____
____ In-dwelling catheter _____
____ Shunt _____
____ Psychiatric condition (type) _____
____ Respiratory complications (type) _____
____ Seizures (list type, frequency and duration) _____

____ Skin integrity issues, skin breakdown, skin/decubitus ulcers _____
_____
____ Chiari II malformation, tethered cord (include release date) _____
_____
____ Spinal fusion or internal fixators (specify area, type, vertebrae involved):
_____
____ Other(please specify)
_____

Physician's Statement

In my capacity as medical advisor, I consent to the participation of in the therapeutic/recreational horseback riding program and/or the equine assisted therapy program at Reins To Recovery, Inc. Therapeutic Riding Center. I certify that all of the information that I have given is accurate and represents a complete medical history.

Physician's name:_____Date:_____

Address or stamp: _____

Physician's signature: _____

Client's full name: _____

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EMERGENCY INFORMATION and RELEASE

Rider/Client's name:_____
Date of Birth: _____
Street Address:_____
City/Town:_____ State:_____zip code:_____
Home phone:_____ Email: _____
Work phone: _____ Fax number: _____
Cell phone: _____
Parents/legal guardian names:

_____

Emergency Contact

In the case of a medical emergency, please contact the following (other than yourself):

Name:_____ Relationship:_____
Phone 1:_____ Phone 2: _____
Name:_____ Relationship: _____
Phone 1: _____ Phone 2: _____
Name:_____ Relationship: _____
Phone 1:_____ Phone 2: _____

Preferred medical facility

Name: _____
Address: _____

Insurance Information

Health Insurance company name: _____
Policy holder's name: _____
ID number: _____

Authorization for Emergency Medical Treatment

In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving services or while being on the property of Reins To Recovery, Inc. Therapeutic Riding Center, I authorize Reins To Recovery, Inc. Therapeutic Riding Center to:

1. Secure and retain medical treatment and transportation as needed, and
2. Release client medical and treatment records upon request to the authorized individual or agency involved in the medical emergency care of the client.

3. This authorization includes X-ray, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by the attending physician (This provision will only be invoked if the person(s) listed above is/are unable to be reached).

Client/Legal guardian consent signature:_____
Print full name: _____
Date: _____

ALL PAGES OF THIS FORM MUST BE UPDATED ANNUALLY