Adaptive Riding Participant Application

Participants Information

Full Name: _____ **DOB:** _____ **Age:** _____

Height: _____ **Weight:** _____ **Gender** ◯ **Male** ◯ **Female**

Address: _____

Phone # _____

Diagnosis: _____

Date on set: _____

Regional Center Client? ◯ **Yes** ◯ **No**

If yes, please provide CSC email and phone #

Email: _____ **Phone #** _____

Ethnicity:

◯ Caucasian ◯ African American ◯ Hispanic/ Latino
◯ Asian/Pacific Islander ◯ Other/Unknown ◯ Decline to Answer

Parent/Guardian Information

1) Parent/ Legal Guardian Full Name _____
Cell Phone # _____ **Email:** _____
Relationship to Participant: _____ ◯ **Single** ◯ **Married** ◯ **Divorced**

2) Parent/ Legal Guardian Full Name _____
Cell Phone # _____ **Email:** _____
Relationship to Participant: _____ ◯ **Single** ◯ **Married** ◯ **Divorced**

Is either parent/guardian an active member of the military? ◯ **Yes** ◯ **No**
How did you hear about our facility? _____
Are you willing to help NDR with donations or volunteer hours? ◯ **Yes** ◯ **No**

Short & Long Term Goals

3 Short term goals:

1) _____
2) _____
3) _____

3 Long term goals:

1) _____
2) _____
3) _____

Schedule Preference

What is your availability during the week and times? _____
Has the participant ridden previously? ◯ Yes ◯ No
If yes, where? _____

Please email completed form to office@ndrtherapeuticriding.org

Participant Health History

Health History

Does the participant have a medical diagnosis? ◯ Yes ◯ No
If yes, please describe: _____
Does the participant walk independently? ◯ Yes ◯ No
Does the participant have poor balance? ◯ Yes ◯ No
Does the participant have speech difficulties? ◯ Yes ◯ No
Does the participant have difficulties with hand-eye coordination (fine motor skills)? ◯ Yes ◯ No
Does the participant have difficulties with walking or running (gross motor skills)? ◯ Yes ◯ No
Does participant have any allergies or breathing problems? ◯ Yes ◯ No
If yes, please explain: _____
Does the participant have any emotional or behavioral problems? ◯ Yes ◯ No
If yes, please explain: _____
Does the participant have any heart or circulation problems? ◯ Yes ◯ No
If yes, please explain: _____
Does the participant have short- or long-term memory loss? ◯ Yes ◯ No
Does the participant have a fear of heights? ◯ Yes ◯ No
Does the participant have a fear of animals? ◯ Yes ◯ No
Is the participant on any medication?
If yes, please list below:

_____

_____

What are some activities or things the participant likes?

_____

_____

_____

What are some activities or things the participant dislikes?

_____

_____

_____

I, the undersigned, declare that the above information is true and accurate. I understand I am financially responsible for all charges whether or not paid by insurance or elsewhere. I hereby authorize NDR Therapeutic Riding & Therapy Services to release all information necessary to secure the payment of benefits.

_____ _____

Date Signature of Parent/ House Representative/ Legal Guardian

Please email completed form to office@ndrtherapeuticriding.org

In Case of Emergency Authorization

Authorization for Emergency Medical Treatment

Participants Full Name: _____ DOB: _____

Address _____

Physicians Name: _____ Preferred Medical Facility: _____

Health Insurance Provider: _____ Policy # _____

Allergies to medication? ◯ Yes ◯ No If yes, please explain: _____

Current Medication (if applicable): _____

In the event of an emergency and medical aid/ treatment is required, I, the parent/legal guardian, (please choose an option):

◯ Authorize ◯ Do not Authorize

NDR Therapeutic Riding & Therapy Services to secure and retain medical treatment and transportation if needed; along with releasing clients record upon request to the authorized individual or agency involved in the medical emergency.

The authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by physician. This provision will only be invoked if the person(s) are unable to be reached.

_____ _____

Signature of parent/ Legal Guardian Date

Emergency Contacts

Please list 3 ICE contacts in case of emergency.

1) **Full Name:** _____ **Relation:** _____

Cell Phone #: _____ **Email:** _____

2) Full Name: _____ **Relation:** _____

Cell Phone #: _____ **Email:** _____

3) Full Name: _____ **Relation:** _____

Cell Phone #: _____ **Email:** _____

Please email completed form to office@ndrtherapeuticriding.org

Participant Photo Release

I, _____ ◯ Consent ◯ Do not Consent

for NDR Therapeutic Riding & Therapy Services the use and reproduction of any and all photographs and any other audio/visual materials taken of my child/myself for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program. I agree that NDR Therapeutic Riding & Therapy Services has complete ownership of such pictures, etc. including copyright and may use them, for a purpose consistent the NDR Therapeutic Riding & Therapy Services program mission. I acknowledge I will not recieve any compensation, etc. for the use of these pictures, etc. and hereby release NDR Therapeutic Riding & Therapy Services and any of its agents and assigns from any and all claims which arise or are in any way connected with such use.

◯ I give consent to NDR Therapeutic Riding & Therapy Services to use my name/child's name and likeness to promote the program, its fiscal agent, and/or their activities. I consent to allow use in the following ways:

- Social Media (Facebook & Instagram @ndrtherapeuticriding)
- Printed Materials (photos, illustrations, bulletins, publications)
- Promotional Materials (advertisements, flyers, exhibitions)
- Videos

◯ I decline the use of my/my child's image, likeness, voice and/or appearance in any way.

I, the undersigned, declare that the above information is true and accurate.

_____ _____

Signature of Parent/ Legal Guardian/ House/ Responsible Party **Date**

Please email completed form to office@ndrtherapeuticriding.org

Office Policies

Appointment Policy- Zero Tolerance Policy

It is important that Participants understand that securing a recurring appointment entails coordination of staff, volunteers, and horses. **If a lesson needs to be cancelled, NDR requires a 48-hour notice to cancel lessons. The Participant will be charged for the missed/canceled lesson in full**. Missed lessons, due to sickness, can be rescheduled *based on availability* in the schedule, but cannot be guaranteed. **Limit one sick make up lesson in 6-week period.** Participants are strongly encouraged to arrive 10-15 minutes prior to their lesson and be prepared to start on time. Scheduled lesson times range from 1/2 hour to 1 hour. **Any missed/canceled/late lessons, regardless of reason, will be charged directly to participant/responsible party of participant/House.** For ½ hr. lessons, if the participant arrives 10 minutes late, the lesson will be cancelled, and participant/responsible party will be charged full amount of the lesson. For 1-hr. lesson, if participant arrives 15 minutes late, lesson will be cancelled, and participant/responsible party will be charged full amount of the lesson.

Please be aware that NDR Therapeutic Riding does not cancel lessons due to weather conditions, however we reserve the right to cancel when we deem weather conditions to be unsafe for participants, staff and horses. We will continue to hold sessions as scheduled and can provide unmounted activities that will work on the Participant's goals. **To hold spots, participant must pay for any missed lesson regardless of reason. Any missed/canceled/late lessons, regardless of reason, will be charged directly to participant/responsible party of participant/House.**
All payments owed must be paid prior to next lesson or participant will not be able to participant in lesson.

Program Participation & Eligibility

Program eligibility is determined at the time of the Adaptive Riding Assessment; the 1st step in our program. From the Assessment, we deem which type of lessons would best fit your riders goals and needs. **Due to weight limit for horses being under 200lbs, we reserve the right to request weight verification from a licensed practitioner**. Ground lessons will be provided until weight verification. While we strive to provide our services consistently, please understand that various factors may occasionally affect our ability to guarantee services and eligibility. **We reserve the right to decline service.**

Appropriate Attire

Sturdy closed-toe shoes (riding boots with a heel for adaptive riding preferred); comfortable, appropriate, non-restrictive clothing; Participants (whether ground based or adaptive riding) **must wear ASTM-SEI helmets and gait belts.**

Payment Policy

Payments are due at time of service for non-Regional Center participants. NDR Therapeutic Riding charges for each lesson given. Lessons can be ground-based, adaptive riding, or a combination of both. Lesson type is determined by our **PATH Certified Instructors**.

- $109- Adaptive Riding Assessment (one-time fee)
- $126- 1 hour individual private lesson
- $97- 30 minute individual private
- $85- 1 hour group lesson
- $45 Non-Ambulatory Assistance
- $115/day horse camp

Note: Prices are subject to change

We accept:

- Zelle (ndrtherapeuticriding@gmail.com)
- Venmo @NDR-TherapeuticRiding
- QuickBooks (processing fees apply)

We are approved Vendors with:

- Third Party Payments from Self Determination
- Regional Center Approved Vendor
- River Springs Charter Schools

Email of person financially responsible _____ **Phone number of person financially responsible** _____

I hereby acknowledge that I have read and fully understand all the Office Policies.

Printed name of person financially responsible _____ **Signature of Person financially responsible** _____ **Date**

Please email completed form to office@ndrtherapeuticriding.org

Regional Center Consumer Notice

Regional Center Clients Only

I, (Financially Responsible Party of Participant/House/Facility/ Guardian/ Conservator) _____ is aware and fully understands he/she/we is (are) responsible for a full lesson cost payment if more than 10 minutes late to lesson. There are no makeup lessons available, unless missing lesson due to sickness **(limit 1 sick make-up in a 6-week period)** If a scheduled lesson needs to be canceled, participant/parent is required to call or text our Cancelation line and leave a message with rider's name, and scheduled appointment time. **Cancelation line 951-675-5043.** The entire lesson fee will be charged if lesson is missed. Regional Center is not responsible for payment. Financially Responsible Party of participant will be charged. Payment must be paid prior to next lesson, or the participant cannot ride.

If participant has 2 canceled lessons in one month, they will be taken off the schedule until CSC of Regional Center is notified. A meeting will be attempted with NDR Therapeutic Riding's Representative, participant, family, and CSC to determine a plan of action via in-person or via teleconference. Members of the Interdisciplinary Team (IDT) will be notified, and an IDT meeting will be scheduled. The IDT team will meet to discuss potential modifications to ensure all possible strategies are in place to protect the health and safety of the individual and staff, prior to issuing a 30-day notice to exit the NDR Therapeutic Riding program and/or NDR Therapy Services program.

_____ aware and fully understands he/she is responsible for full cost of the lesson payment and charged as Regional Center will **not** pay for (any missed/canceled lessons), therefore:

Initial

_____ If more than 10 minutes late for a 30-minute lesson, the horse will be put away and there will be no lesson for that day, and you will be charged.

_____ If more than 15 minutes late for a 1- hour private lesson, the horse will be put away and there will be no lesson for that day, and you will be charged

_____ If more than 15 minutes late for a 1-hour group lesson, the horse will be put away and there will be no lesson for that day, and you will be charged

_____ No show

_____Any missed/canceled lessons, regardless of reason, will be charged directly to participant/responsible party of participant/House and **all payments owed must be paid prior to next lesson or participant will not be able to participant in lesson. Payment can be made by coming in the office prior to next lesson or requesting an invoice.**

- 1 sick make-up allowed in 6-week period

_____ _____ _____

Signature of Responsible Party of Participant (RPP) | Printed name of RPP | Date

_____ _____ ____ _____

Billing Address | City | State | zip code

CSC Contact Information- Required

Your child's CSC is required in order for Regional Center to fund lessons. If not provided, you will be billed as a out-of-pocket client.

Name: _____ **Phone #** _____

Email: _____

Please email completed form to office@ndrtherapeuticriding.org

Release and Indemnity Agreement

I, the undersigned, _____, am fully understanding that there are risks, including the risk of injury the participant, rider/handler and/or horse when riding, interacting, handling, and transporting horses, hereby waive and release NDR Therapeutic Riding & Therapy Services, any agents and employees, NDR Board/ Officers or operators from any and all claims, causes or action., or liability for negligent acts or omissions of NDR Therapeutic Riding, operators, agents and employees.

Furthermore, I agree to and hereby waive and release NDR Therapeutic Riding & Therapy Services, Board/Officers, agents and employees for any damages of any kind or nature arising from any cause whatsoever, including but not limited to, loss by fire, theft, running away, illness or injury to any person or other animals on the property. I agree that I shall be solely responsible at all times for any and all acts of the horse(s) that I own, lease, ride, train, or use other horse(s) owned or leased by NDR Therapeutic Riding & Therapy Services, while the horse(s) is under my control, possession, or care. I agree to hold NDR Therapeutic Riding & Therapy Services, NDR Board/ Officers, agents or employees, harmless from any claim resulting from damage or injury/ caused by any horse, the owner, or lease-holder of any horse, a boarder, or guest of a boarder or property user and agree to pay any legal fees and expenses incurred by NDR Therapeutic Riding & Therapy Services, in the defense of such claim.

I am responsible for boldly injury or property damage which I or my child or legal ward should sustain on NDR Therapeutic Riding & Therapy Services premises while participating, interacting, riding, handling, working a horse, and/or working using the premises, and any time I or my child or legal ward shall lose from employment or school or other activity, and for medical expenses or any other expenses incurred because of such bodily injury or property damage; and that I hereby for myself; my heirs, administrator, release and discharge NDR Therapeutic Riding & Therapy Services, and its board operators, agents, employees, officers, and all other participants of and from all claims, demands, actions, and cause of action for such injuries sustained to my person or property. I shall be liable to NDR Therapeutic Riding & Therapy Services, personnel and property caused by the horse(s) while under my control.

I have been advised that in order to participate in equine-assisted activities on the premises of NDR Therapeutic Riding & Therapy Services, an ATSM certified helmet must be worn at all times when interacting with and/or handling a horse.

I hereby acknowledge that riding and jumping horses is a dangerous activity. Therefore, I expressly assume the risk involved when engaging in riding, jumping, or other related activities at NDR Therapeutic Riding & Therapy Services. I hereby release and discharge NDR Therapeutic Riding & Therapeutic Services, NDR Board/ Officers, operators, agents and employees from any and all liability from any accident that may occur as a result of engaging in riding, jumping, or their related activities at NDR Therapeutic Riding & Therapy Services.

I agree to assume all responsibility for my competence and ability as the rider or handler of the horse(s) owned, leased, trained, or ridden by me or as the rider or handler of the horse(s) owned, leased, trained, or ridden by me or as the rider of the horse(s) belonging to NDR Therapeutic Riding & Therapy Services, agents, or employees, property users, or boarders are not responsible for the prior named rider's competence or riding ability.

I, _____, hereby acknowledge that I have read and understood the "Release of Liability Agreement" to its entirety.

_____ _____

Signature of Parent/ Legal Guardian/ House/ Responsible Party **Date**

Please email completed form to office@ndrtherapeuticriding.org

Medical History & Physician's Statement

To be completed by a licensed Physician Only

Participant: _____ **DOB:** _____ **Height:**_____ **Weight:** _____

Diagnosis: _____ **Date of onset:** _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ **Controlled?** ◯ **Yes** ◯ **No** **Date of last seizure:** _____/____/____

Shunt Present: ◯ **Yes** ◯ **No** **Date of last revision:** _____

Special Precautions/Needs: _____

Wheelchair: ◯ **Yes** ◯ **No** **Independent Ambulation:** ◯ **Yes** ◯ **No**

Braces/Assistive Devices: ◯ **Yes** ◯ **No**

For those with Down Syndrome

Atlanteans Interval Exam Results: **Date:**_____

Neurological Symptoms of Atlantoaxial Instability:

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

	Yes	No	Comments
Auditory			
Visual			
Tacticle 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 PATH Member Center will weigh the medical information given against the existing precautions & contraindications. Therefore, I refer this person to the PATH Member Center for ongoing evaluation to determine eligibility for participation.

Name/Title:_____ **MD DO NP PA Other:**_____

Signature: _____ **Date:** _____

Address: _____ **Phone:** _____

Please email completed form to office@ndrtherapeuticriding.org