

APPLICATION FOR THERAPEUTIC RIDING

PARTICIPANT NAME _____ AGE: _____

ADDRESS _____ CITY/STATE _____ ZIP _____
HOME PHONE _____ DATE OF BIRTH _____ HEIGHT _____ WEIGHT _____

PARENT/GUARDIAN _____ E-mail: _____

DISABILITY _____ DATE OF ONSET _____

EDUCATIONAL PLACEMENT _____ SCHOOL _____

Employer:	Business Phone & hours:
Father/husband name & employer:	Business Phone & hours:
Mother/wife name & employer:	Business Phone & hours:

PHYSICIAN NAME _____

ADDRESS _____ CITY/STATE _____ ZIP _____

OFFICE PHONE _____

* * * * *

No participant can be accepted for participation until the Parent/Guardian has completed this form. If the participant is of legal age and mentally competent, he/she may complete the form without parent's supervision. Every effort will be made to avoid any accident, however, NO LIABILITY can be accepted by any of the organization's trustees, agents, employees, each and every one of its members and associates, the property owners upon whose land the lessons are conducted.

I would like _____ to participate in TROT. I have discussed this with the child's (my) doctor. Furthermore, I grant permission to a TROT instructor or therapist to contact my doctor or therapist for further clarification of medical information if needed (this information will be treated with confidentiality). I understand that NO LIABILITY can be accepted by any of the organizations concerned with this instruction or therapy, including THERAPEUTIC RIDING OF TUCSON (TROT), INC. I understand that the final decision regarding acceptance, selected therapeutic activities, and continued participation rests with the TROT staff, upon due consideration of the individual's special needs and the safety of the participant, staff, volunteers and horses.

SIGNATURE OF PARENT (S) / GUARDIAN _____ DATE: _____

SIGNATURE OF PARTICIPANT OF LEGAL AGE _____ DATE: _____

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( Office use only ) Date application received \_\_\_\_\_ Approved: \_\_\_\_\_ Program Director

## Authorization for Emergency Medical Treatment Form

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY/ST \_\_\_\_\_ ZIP \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_ PHONE \_\_\_\_\_

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 of an emergency medical aid/ treatment is required due to illness or injury during the process of receiving services, or while being on the TROT premises, I authorize TROT 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

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. Emergency services from this area utilize Tucson Medical Center or St. Joseph's Hospital.

Other preference: \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_  
(Parent, or legal guardian, or legally competent adult rider over 21)

### NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/ aid in the case of illness or injury during the process of receiving services or while on the TROT premises.

- ☐ Parent or legal guardian will remain on site at all times during equine assisted activities.
- ☐ In the event of emergency treatment/ aid is required, I wish the following procedure to take place:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_  
(Parent, or legal guardian, or legally competent adult rider over 21)

*\*This form must be updated annually*

**PHYSICAL, OCCUPATIONAL, or SPEECH/LANGUAGE THERAPY EVALUATION**

To be completed by participant's primary therapist (PT OT or SLP). \*If applicant is not receiving PT/OT/or SLP services at this time, please sign here to indicate that this form does not apply: \_\_\_\_\_

Signature

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY/ST \_\_\_\_\_ ZIP \_\_\_\_\_

DISABILITY \_\_\_\_\_ SCHOOL \_\_\_\_\_

THERAPIST: \_\_\_\_\_ PHONE \_\_\_\_\_

MUSCLE TONE \_\_\_\_\_

ROM / JT. DEFORMITIES \_\_\_\_\_

BALANCE / COORDINATION \_\_\_\_\_

SELF-HELP SKILLS \_\_\_\_\_

MOBILITY \_\_\_\_\_

ASSISTIVE DEVICES \_\_\_\_\_

POSTURE / SCOLIOSIS \_\_\_\_\_

ASSOCIATED REACTIONS / ABNORMAL REACTIONS \_\_\_\_\_

COMPREHENSION OF VERBAL INSTRUCTION \_\_\_\_\_

SPEECH / DISCOURSE \_\_\_\_\_

PSYCHO-SOCIAL/ BEHAVIORAL \_\_\_\_\_

EXERCISES OR POSITIONS TO AVOID \_\_\_\_\_

OTHER SPECIAL PRECAUTIONS \_\_\_\_\_

PRESENT GOALS OF P.T. / O.T. / SLT PROGRAM \_\_\_\_\_

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

*\*This form must be updated annually.*

**TROT MEDICAL HISTORY/PHYSICIAN'S RELEASE**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_

NAME OF PARENT/GUARDIAN \_\_\_\_\_

DIAGNOSIS \_\_\_\_\_ DATE OF ONSET \_\_\_\_\_

**\*\* FOR PERSON WITH DOWN SYNDROME: Cervical X-Ray for Antlanto -Axial Instability**  
Positive \_\_\_\_\_ Negative \_\_\_\_\_ X-Ray date \_\_\_\_\_

Tetanus shot: No  \_\_\_\_\_ Yes  \_\_\_\_\_ Date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Seizures: Type: \_\_\_\_\_ Controlled? \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

Medications: \_\_\_\_\_

| Areas               | Normal | Problems/Deficits | Comments/Surgeries |
|---------------------|--------|-------------------|--------------------|
| AUDITORY            |        |                   |                    |
| VISUAL              |        |                   |                    |
| SPEECH              |        |                   |                    |
| CARDIAC             |        |                   |                    |
| CIRCULATORY         |        |                   |                    |
| PULMONARY           |        |                   |                    |
| NEUROLOGICAL        |        |                   |                    |
| ORTHOPEDIC          |        |                   |                    |
| SCOLIOSIS:          |        |                   |                    |
| <b>type/degree</b>  |        |                   |                    |
| ALLERGIES           |        |                   |                    |
| LEARNING DISABILITY |        |                   |                    |
| MENTAL IMPAIRMENT   |        |                   |                    |
| PSYCH. IMPAIRMENT   |        |                   |                    |
| SHUNT               | Yes :  | No:               |                    |
| GI TUBES            | Yes:   | No:               |                    |
| CATHETER            | Yes:   | No:               |                    |
| OTHER               |        |                   |                    |

MOBILITY: INDEPENDENT AMBULATION yes \_\_\_\_\_ no \_\_\_\_\_  
 BRACES yes \_\_\_\_\_ no \_\_\_\_\_  
 CRUTCHES yes \_\_\_\_\_ no \_\_\_\_\_  
 WHEELCHAIR yes \_\_\_\_\_ no \_\_\_\_\_

OTHER SPECIAL PRECAUTIONS: \_\_\_\_\_

I have reviewed the **CONTRAINDICATIONS** on reverse side of this form. In my opinion this patient has none of these contraindications and may participate in supervised equestrian activities. In conjunction with these activities, I concur in the referral of the participant to a PT/ OT/ or SLP or other health care professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian or therapy program. I understand that the final decision regarding acceptance rests with the TROT staff, upon due consideration of the participant's special needs, precautions and contraindications, and the safety of the participant, staff, volunteers and horses. **This form MUST BE signed and stamped by a physician.**

PHYSICIAN'S NAME (pleaseprint) \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

**PARTICIPANT NAME** (please print) : \_\_\_\_\_

**PARTICIPANT RELEASE**

**KNOWN BY ALL PRESENT:**

The undersigned understands and agrees that there is inherent risk of injury in all equine-related activities, both mounted and non-mounted. It is understood that horses may stumble, bite, run or make unpredictable movements which may cause a participant to be injured or fall from the horse. I am willing and able to accept full responsibility for my own safety and welfare, and that of my child or ward.

The horseback-riding sessions in particular will focus on acquisition of riding skills as well as therapeutic benefits to the individual participants. As part of typical skill development, the instructor may progress the rider from two side-walkers to one side-walker to no side-walker and eventually to independent riding if the instructor decides that it is appropriate for the rider's ability.

I have been advised and I understand that the utmost attention will be given to the safety of the rider. I am also fully aware that the risk of a fall from the horse is greater as the rider's independence increases. Knowing the potential of increased risk, I agree and support the participation of the above named in therapeutic horseback riding.

I do hereby release and discharge TROT, Inc. its Board of Directors, Instructors, Therapists, paid and volunteer staff, and horse owners from any and all responsibility or liability to me and/or my child in connection with any injuries suffered by me or my child as a result of my activity involving TROT horses/ponies or property.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Signature (parent, guardian, adult rider) \_\_\_\_\_

**PARTICIPANT NAME** (please print): \_\_\_\_\_

**PHOTO RELEASE**

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants: \_\_\_\_\_ does not grant: \_\_\_\_\_ Therapeutic Riding of Tucson Inc. permission to take or have taken still and moving photographs and films including television pictures of the above named participant and consents: \_\_\_\_\_ does not consent: \_\_\_\_\_ and authorizes Therapeutic Riding of Tucson Inc., its advertising agencies, news media, and any other persons interested in this organization and its work, to use and reproduce the photographs, films and pictures and to circulate and publicize the same by all means including without limiting the generality of the foregoing newspapers, television media, brochures, pamphlets, instructional material, books and clinical material.

With respect to the foregoing matters, no inducements or promises have been made to us/me to secure our/my signature(s) to this release other than the intention of Therapeutic Riding of Tucson Inc. to use or cause to be used such photographs, films and pictures for the primary purpose of promoting and aiding Therapeutic Riding of Tucson Inc. and its work.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Signature (parent, guardian, adult rider) \_\_\_\_\_

**INSTRUCTOR/VOLUNTEER PROGRAM PLANNING**

I hereby grant the NARHA Certified Instructors at Therapeutic Riding of Tucson, Inc. permission to confidentially discuss my/my child's disability with members of the volunteer team in order to effectively create lesson plans and set goals for the most positive outcome throughout the time of my/my child's participation in the program.

\_\_\_\_\_ (CONSENT-initial) \_\_\_\_\_ (NON-CONSENT-initial)

## TROT SCHEDULING REQUEST FORM

2011-2012

Participant's Name \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

PHONE: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (cell) \_\_\_\_\_ (e-mail) \_\_\_\_\_

Best day & time to call: \_\_\_\_\_ and preferred number: \_\_\_\_\_

**FALL TERM:** September 12-December 17, 2011

**SPRING TERM:** January 9-April 7, 2012

**SUMMER TERM:** April 16-May 25, 2012

**AVAILABILITY:** Please indicate **all** of the times that you would be available to attend by checking  appropriate boxes.

WHITE AREAS = Hours available for TROT program scheduling.

|       | MONDAY                   | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY |
|-------|--------------------------|---------|-----------|----------|--------|----------|
| 9:00  |                          |         |           |          |        |          |
| 10:00 |                          |         |           |          |        |          |
| 11:00 |                          |         |           |          |        |          |
| 12:00 | <i>Horses lunch time</i> |         |           |          |        |          |
| 1:00  |                          |         |           |          |        |          |
| 2:00  |                          |         |           |          |        |          |
| 3:00  |                          |         |           |          |        |          |
| 4:00  |                          |         |           |          |        |          |