



**TROT Rider Package Check List**

All of the forms listed below are required to be completed, checked, signed and dated as indicated prior to the start of rider participation and annually thereafter.

**To be completed by rider, parent or caregiver by**

- 1-Rider package check list
- 2-Rider registration form
- 3-Contact and tuition payment
- 4-Rider Release
  - a) Liability release
  - b) Confidentiality agreement
  - c) Photo and video release
- 5-Annual Health History and Contact Information Update Form
- 6-Possible reasons for discharge form
- 7-Rider goal sheet
- Payment: Check  or Credit card

**To be completed by the riders physician**

- 8-Information for Physician (Precautions and Contraindications)
- 9-Rider health history/physician assessment form
  - a) Cervical X-ray results for Atlanto-axial Instability for persons with Down Syndrome (if applicable)
- 10-Physician release

**Optional Information if applicable to the rider’s goals/needs**

- 11-Physical/Occupational/Speech Therapy Forms
- 12-I.E.P. Individual Education Plan

**For office use only**

Forms	1	2	3	4	5	6	7	8	9	10	11	12

**Rider Registration**

**Program Information**

Date\_\_\_\_\_

Participant Name: \_\_\_\_\_ Phone: \_\_\_\_\_

DOB\_\_\_\_\_ Age\_\_\_\_\_ Height\_\_\_\_\_ Weight\_\_\_\_\_ Gender M F

Primary Diagnosis \_\_\_\_\_

Secondary Diagnosis \_\_\_\_\_

Mobility status (walks unassisted, assistive devices, etc) \_\_\_\_\_

Address \_\_\_\_\_

Communication (verbal, non-verbal signs) \_\_\_\_\_

Behaviors (impulsive, fearful, frustration tolerance) \_\_\_\_\_

\_\_\_\_\_

Medications Taken \_\_\_\_\_

Seizures (if applicable please describe) \_\_\_\_\_

Limitations \_\_\_\_\_

Allergies \_\_\_\_\_

Skin sensitivity \_\_\_\_\_

Participant's occupation/ school grade level \_\_\_\_\_

Affiliate Program if applicable \_\_\_\_\_

**Personal Goals** (fill in the areas that apply)

Physical \_\_\_\_\_

Cognitive \_\_\_\_\_

Social/Behavioral \_\_\_\_\_

Emotional \_\_\_\_\_

Life skills \_\_\_\_\_

Other \_\_\_\_\_

**Availability for the TROT Program** (Check all available times and days)

Tuesday am\_\_\_\_

Thursday am\_\_\_\_

Saturday am\_\_\_\_

Tuesday afternoon\_\_\_\_

Thursday afternoon\_\_\_\_

Saturday afternoon\_\_\_\_

**Start Date**\_\_\_\_\_

(Decided at the assessment)

**Client Contact and Tuition Information**

Participant Name: \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Email Address \_\_\_\_\_

Names of parents/guardian:

Father \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Mother \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Best Emergency Contact: Name \_\_\_\_\_

Phone \_\_\_\_\_ Cell \_\_\_\_\_

Parent occupation and employer:

Father \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother \_\_\_\_\_ Work Phone \_\_\_\_\_

How were you referred to TROT? \_\_\_\_\_

**2018 Program Tuition Payment Details**

Please tell us how you will be paying:

Credit Card

I, \_\_\_\_\_ authorize TROT to charge \$ \_\_\_\_\_ to my credit card.

Account # \_\_\_\_\_ Expiration Date \_\_\_\_\_ 3-Digit Code \_\_\_\_\_

Name on card \_\_\_\_\_ Signature \_\_\_\_\_

Check (please make payable to TROT)

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

I understand and agree that all paperwork must be up to date in the calendar year in which I am participating. All tuition is to be paid prior to the start of each semester in full (\$540) or in 3 monthly installments of \$180. If applicable, all scholarship forms must accompany the rider application.

Signature of Rider or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Rider Liability Release, Confidentiality Agreement, Photo and Video Release**

Participant Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian/ Conservator (if applicable) \_\_\_\_\_

**Liability Release:**

Name of Parent/Guardian/Conservator \_\_\_\_\_

I acknowledge the risks and potential risks for horseback riding and activities in and around a facility where horses are kept and farm machinery operated. However, I feel that the possible benefits to me/my son/my daughter/my ward are greater than the risk assumed. Intending legally to bind myself, my heirs, and assigns, executors or administrators, I hereby waive and release forever all claims for loss or damages of any kind against TROT, its Board of Directors, Instructors, Therapists, aids, Volunteers and employees for any and all injuries and losses that I/my son/my daughter/my ward may sustain while participating in the TROT program. This release includes without limitation the risk of negligent instruction and supervision. I engage in activities at TROT voluntarily with knowledge of the risks and I assume all risks of injury, death, and property damage that may result. I agree to bear any loss myself. I acknowledge that TROT and the property owners are materially relying on this waiver and assumption of risk in allowing me/my son/my daughter/my ward to participate in activities at TROT.

Date \_\_\_\_\_ Signature \_\_\_\_\_

(Participant, Parent or Caregiver)

**Confidentiality Agreement:**

I understand that all the personal information (written and verbal) about participants at TROT is confidential and not to be shared with anyone without expressed written consent of the participant and their parent/guardian in the case of a minor.

Date \_\_\_\_\_ Signature \_\_\_\_\_

(Participant, Parent or Caregiver)

**Photo and Video Release:**

\_\_\_\_ I consent to and authorize                      \_\_\_\_ I do not consent to nor do I authorize

The use and reproduction by TROT of any other audio/visual materials taken of me/my son/my daughter/my ward for distribution to the public for promotional printed materials, educational activities or for any other use for the benefit of the program.

Date \_\_\_\_\_ Signature \_\_\_\_\_

(Participant, Parent or Caregiver)

**TROT Therapeutic Riding Of Tucson**  
**Annual Health History and Contact Information Update Form**

Date: \_\_\_\_\_

Name of Participant: \_\_\_\_\_

Name of Parents/Guardian (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail: (Please print clearly and carefully): \_\_\_\_\_

Participant DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Diagnosis + changes: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_ Physicians Name: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_

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

Allergies: \_\_\_\_\_

Precautions/Restrictions: \_\_\_\_\_

Please explain any recent changes in health or behavior status: \_\_\_\_\_

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Relationship: \_\_\_\_\_

**Possible Reasons for Client Discharge**

Please be advised of the following reasons that may lead to discharge from the riding program.

1. The client has reached all of their goals and is ready to graduate.
2. The client's potential to maintain head and neck control while riding presents a safety concern.
3. Inability to follow directions is interfering with progress toward goals.
4. Uncontrolled and/or inappropriate behavior that constitutes a safety risk to client, staff and/or horse.
5. Client exceeds weight that can safely be managed by staff, volunteers, and/or horses.
6. Any change in the client's medical, physical, cognitive, or emotional condition that makes therapeutic riding inappropriate.
7. Three scheduled appointments are missed without prior cancelation.
8. Non-payment of fees as originally agreed.

I understand and agree with the possible reasons for client discharge.

Signature of Client or Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

**Rider Goals**

**Please help us help you get the most out of your classes by filling out the following goal setting sheet. Thank you.**

Rider Name: \_\_\_\_\_

Parent Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

Class Day/Time: \_\_\_\_\_

All goals are reflective of the next term. The categories are meant as a guideline and all categories may not apply to all students.

Personal Riding Goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physical Goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Cognitive Goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Social Goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Long-term goal over the next year.

Goals Dated: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Information for Physician

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. **Please complete the TROT Medical Release and Health History Assessment forms. Also, please note if any of the following conditions are present, and to what degree.**

### Orthopedic

Spinal Fusion  
Spinal Instabilities/Abnormalities  
Atlantoaxial Instabilities  
Scoliosis  
Kyphosis  
Lordosis  
Hip Subluxation and Dislocation  
Osteoporosis  
Pathological Fractures  
Coxas Arthrosis  
Heterotopic Ossification  
Cranial Deficits  
Spinal Orthoses  
Internal Spinal Stabilization Devices

### Neurological

Hydrocephalus/shunt  
Spina Bifida  
Tethered Cord  
Chiari II Malformation  
Hydromyelia  
Paralysis due to Spinal Cord Injury  
Seizure Disorders

### Medical/Surgical

Allergies  
Cancer  
Poor Endurance  
Recent Surgery  
Diabetes  
Peripheral Vascular Disease  
Varicose Veins  
Hemophilia  
Hypertension  
Serious Heart Condition  
Stroke (Cerebrovascular Accident)

### Secondary Concerns

Behavior Problems  
Age under Two Years  
Age Two - Four Years  
Indwelling Catheter  
Acute Exacerbation of  
Chronic Disorder

**(Please give to the rider's physician as a guideline for Therapeutic Riding)**



**Annual Rider Health History**

Rider Name \_\_\_\_\_ DOB \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Address \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset \_\_\_\_\_

Past/Prospective Surgeries: \_\_\_\_\_

Medications \_\_\_\_\_

Seizures Y N Type \_\_\_\_\_ Controlled Y N Date of Last Seizure \_\_\_\_\_

Shunts/Implants/Appliances \_\_\_\_\_

Hospitalizations/Surgery \_\_\_\_\_

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Neurologic Symptoms of Atlanto Axial Instability Yes \_\_\_\_\_

Please indicate and comment on any Special Problem Areas Below:

Area	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological/Sensation			
Bowel/Bladder			
Muscular			
Orthopedic			
Allergies			
Behavior			
Cognition			
Emotional/Psychological			
Other			

## Physician Release

Rider Name: \_\_\_\_\_

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However I understand that TROT will weigh the medical information contained in the physician release form against existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Therapist, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's name, address, and telephone number: (please print, type or stamp):

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

### **Physician Annual Medical Clearance Report for Neurologic Symptoms of Atlanto Axial Instability**

***For All Clients with Down syndrome:***

\_\_\_\_\_ has undergone a neurological exam by a licensed physician to test for symptoms consistent with atlantoaxial instability.

\_\_\_\_\_ has been given medical clearance by the licensed physical below, due to the results of the neurological exam that denies any symptoms consistent with atlantoaxial instability.

Physician name: \_\_\_\_\_

Signature: \_\_\_\_\_

Stamp: