



LIFESPAN FARM

Therapeutic Riding Center

3701 Kidd Lane
Charlotte, NC 28216
Phone - 704.393.0333
Fax - 704.393.0334

www.lifespanservices.org/farmtrc

2009-2010
Rider Registration Packet



Dear Parent, Guardian, or Care Provider,

Thank you for inquiring about LifeSpan Farm – Therapeutic Riding Center. Before completing the Rider Registration Packet please review our eligibility guidelines and fees for our program. If you feel the individual meets our eligibility guidelines and you understand the fees for our program please proceed in completing the Rider Registration Packet. If you have any questions regarding the Rider Registration Packet, please contact LifeSpan Farm – Therapeutic Riding Center at 704.393.0333.

Eligibility Guidelines

To be eligible, individuals at LifeSpan Farm – Therapeutic Riding Center:

1. All new riders must go through an evaluation to evaluate the individual's needs and to determine an appropriate class time.
2. Must be three years of age or older.
3. Must provide, annually, a prescription for riding from a qualified physician.
4. May not have a history of having uncontrolled Gran Mal seizures.
5. For individuals with Down Syndrome: Must have a recent (within twelve months prior to beginning session annually) Atlantoaxial instability verification.

We reserve the right not to serve an individual, based on our ability to SAFELY accommodate his/her needs.

Fees for our Program

A \$20 Registration Fee is due when you submit your registration forms.

All new riders or any rider who has been on a break for more than three months must go through an evaluation. An Evaluation Fee of \$30 is due when you submit your registration forms.

Riding lessons cost \$30 a lesson, but are paid for by the session, i.e. 6 lessons in a session costs \$180. You are required to complete the session registration form for each session and return it by the deadline along with a \$30 non-refundable deposit, which will be credited towards your session cost. If we do not receive the session registration form by its due date we will assign another rider to that class placement. Session cost minus a \$30 non-refundable deposit is due at the first lesson. For example, a session might cost \$180 minus \$30 deposit leaving a balance of \$150 due at first lesson. If payment is made later than the first lesson you will be assessed a \$20 late fee.

We look forward to your participation in our program.

Sincerely,

The Staff at LifeSpan Farm – Therapeutic Riding Center

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Participant's Application, Health History, Photo Release, and Eligibility Verification

General Information

Page 1 of 2

Participant's Name: _____

DOB: _____ Age: _____ Diagnosis: _____ Gender: M F

Address Street: _____

City: _____ State: _____ Zip: _____ Home #: _____

Email Address: _____ Cell #: _____

School/Employer/Institution: _____

Parent/Legal Guardian/Caregiver: _____

Address (if different from above): _____

Phone #: _____ Alternative Phone #: _____

If you are a new applicant:

How did you hear about our program? _____

If referred, please list source and date: _____

If you have any previous riding/horse experience, please describe: _____

If you currently ride at LifeSpan Farm – TRC please list start date: _____

Health History

Diagnosis _____ Date of Onset: _____

Please indicate current or past special needs in the following areas:

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

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Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

Physical Function (i.e. Mobility skills such as transfers, walking, wheelchairs use, driving/bus riding)

Psycho/Social Function (i.e. Work/school including grade completed, leisure interests, relationships, family structure, support systems, companion animals, fears/concerns, etc.)

Goals (i.e. Why are you applying for participation? What would you like accomplish?)

Liability Release

_____ (Individual's name) would like to participate in the therapeutic horseback riding program at LifeSpan Farm – Therapeutic Riding Center. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to me/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against LifeSpan Farm – Therapeutic Riding Center, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in therapeutic horseback riding at LifeSpan Farm – Therapeutic Riding Center.

Signature: _____ Date: _____

Participant (Parent or Legal Guardian if participant is under the age of 18 yrs)

Photo Release

I DO / DO NOT (please circle one) hereby consent to and authorize the use and reproduction by LifeSpan Farm – Therapeutic Riding Center of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Signature: _____ Date: _____

Participant (Parent or Legal Guardian if participant is under the age of 18 yrs)

Eligibility Verification

I certify that _____ (Participant's name) meets the eligibility requirements outlined on opening page of the Rider Registration Packet.

Signature: _____ Date: _____

Participant (Parent or Legal Guardian if participant is under the age of 18 yrs)

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Participant's Authorization for Emergency Medical Treatment Form

Participant's Name: _____ DOB: _____ Phone #: _____

Address: _____

In the event of an emergency, contact:

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Physician's Name: _____ Phone #: _____

Preferred Medical Facility: _____

Health Insurance Co: _____ Policy #: _____

Allergies to medications: _____

Current medications: _____

State any medical information you want supplied to a medical professional in an emergency:

Consent Plan

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of LifeSpan Farm - TRC, my signature below authorizes LifeSpan Farm - TRC 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.

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.

Date: _____ Consent Signature: _____

Participant (Parent or Legal Guardian if participant is under the age of 18 yrs)

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 being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date: _____ Non-Consent Signature: _____

Participant (Parent or Legal Guardian if participant is under the age of 18 yrs)

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LifeSpan Farm – Therapeutic Riding Center Information Regarding Protection of Privacy

This document details how your medical information may be used or disclosed. LifeSpan Farm – Therapeutic Riding Center uses your personal health information primarily for treatment. However, we may disclose your personal health information without prior authorization for public health purposes, for audits, when required by law, and in an emergency. In other situations, LifeSpan Farm – Therapeutic Riding Center policy is to obtain your written authorization before releasing personal health information. You may revoke this authorization at any time. Furthermore, you have the right to access a copy of your personal health information at any time.

I have read and understand LifeSpan Farm – Therapeutic Riding Center policy regarding protection of privacy. I agree to the use and disclosure of my personal health information for purposes detailed in the above paragraph.

Printed Name: _____

Signature: _____

Date: _____

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Supporting LifeSpan Farm - TRC

LifeSpan Farm – TRC is able to operate through the support of many volunteers and financial contributions from the community. To provide one mounted riding lesson, it costs LifeSpan Farm – TRC \$123. The fee for one mounted riding lesson to families is \$30. In order for us to meet the gap of our cost and the fee we charge, we encourage all families to support the program by volunteering as a sidewalker or leader during their rider's lesson or with the planning of various events that help to raise awareness and financial support of LifeSpan Farm - TRC. Any assistance you can provide, no matter how small, is greatly appreciated!

Parent's Name: _____ Home #: _____

Email Address: _____ Cell #: _____

Employer: _____

I would like to volunteer during my rider's class: _____ Yes _____ No If yes, as a _____ Sidewalker _____ Leader

Please note that volunteering during riding classes requires you to complete a Volunteer Training before you can begin.

I would like to become involved in the following as a parent volunteer (please check all that apply):

- Movies in the Barn - Friday's, September 25, 2009, November 6, 2009, April 16, 2010, and May 21, 2010, planning is ongoing
- Fall Festival – Saturday, October 24, 2009, planning is ongoing
- Derby Day Parade – Saturday, May 1, 2010, planning is ongoing
- Auto Bell Car Wash – November 20 through December 19.
- Christmas Tree Sales – Saturday's December 5, 12, and 19 anytime from 8am to 4pm
- Assisting in birthday parties – as needed and will typically be held on Saturday afternoons
- Newsletters – ongoing through out the year
- Merchandising – two times a year for order placement
- Volunteer and Rider Recruitment – ongoing through out the year

My employer will match financial contributions: _____ Yes _____ No

_____ Please contact me about how my employer, school, civic group or organization can support the farm, either through sponsorships or a Corporate Volunteer Day.

I know someone who might be able to assist with the following goods or services: _____

Please add the following family or friends to your database for them to learn more about LifeSpan Farm – TRC:

Name: _____

Name: _____

Address: _____

Address: _____

City: _____ State: _____ Zip: _____

City: _____ State: _____ Zip: _____

Email: _____

Email: _____

Please use additional sheets if necessary.

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Date: _____

Dear Health Care Provider:

Your patient, _____, is interested in participating supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History, Physician's Statement, and Physician's Prescription Forms. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

- Atlantoaxial Instabilities
- Coxas Arthrosis
- Cranial Deficits
- Heterotopic Ossification/Myositis Osifications
- Internal Spinal Stabilization Devices
- Joint Subluxation and Dislocation
- Kyphosis
- Lordosis
- Osteoporosis
- Osteogenesis Imperfecta
- Pathologic Fractures
- Spinal Joint Fusion/Fixation
- Spinal Joint Instabilities/Abnormalities
- Scoliosis
- Spinal Orthoses

Secondary Concerns

- Behavior problems
- Age less than two years
- Age two – four years
- Acute exacerbation of chronic disorder
- Poor Endurance
- Skin Breakdowns
- Indwelling Catherers/Medical Equipment
- Medications – i.e. photosensitivity

Neurological

- Chiari II malformation
- Hydrocephalus/shunt
- Hydromyelia
- Paralysis due to Spinal Cord injury
- Seizure Disorders
- Spina Bifida
- Tethered Cord

Medical/Surgical/Psychological

- Allergies
- Animal Abuse
- Blood Pressure Control
- Cancer
- Cardiac Condition
- Dangerous to self or others
- Diabetes
- Exacerbations of medical conditions (i.e. RA, MS)
- Fire Settings
- Hemophilia
- Hypertension
- Medical Instability
- Migraines
- Peripheral Vascular Disease
- Respiratory Compromise
- Recent Surgeries
- Varicose Veins
- Substance Abuse
- Thought Control Disorders
- Weight Control Disorder
- Stroke (Cerebrovascular Accident)

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,

Parent or Legal Guardian

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Participant's Medical History & Physician's Statement

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

Address: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs: _____

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

Braces/Assistive Devices: _____

For those with Down Syndrome: AtlantoAxial Instability X-Ray, Date: _____ Result: + --

Neurological Symptoms of AtlantoAxial Instability: _____

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

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the 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, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician's Name (please print): _____ MD DO NP PA Other _____

Physician's Signature: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ License/UPIN Number: _____

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Physician's Prescription

Participant's Full Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

Prescription for Therapeutic Horseback Riding

Prescription, where appropriate for evaluation and treatment by a Physical, Occupational and/or Speech Therapist in conjunction with the Therapeutic Horseback Riding Program at LifeSpan Farm – Therapeutic Riding Center:

Recommended Frequency:

Precautions *(all individuals riding are required to wear helmets)*:

Physician's Signature: _____ Date: _____

Please Print, Type or Stamp

Physician's Name (please print): _____ MD DO NP PA Other _____

Physician's Signature: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ License/UPIN Number: _____

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Seizure Activity Information

Please complete this form in its entirety, if applicable.

Date: _____

Participant's Name: _____ Date of Birth: _____ Age: _____

Please take into consideration the following PRECAUTIONS & CONTRAINDICATIONS for seizure activity set for by NARHA:

PRECAUTIONS (which will limit or prevent a person from participation):

- If the motor activity, change in postural tone, loss of motor control, or alteration in consciousness is minor and is not likely to frighten or injure the horse, participant, or staff
- Seizure medications may cause drowsiness or may cause photo sensitivity
- Sensitivity of the horse to seizure activity

CONTRAINDICATIONS (which will prevent a person from participation):

- Seizures accompanied by strong, uncontrollable motor activity or atonic or "drop attack" seizures due to their sudden and complete loss of postural muscle tone
- A change of frequency or type of seizure, until the condition is evaluated
- Inability to manage a participant during an emergency dismount should a seizure occur

Type of seizure(s): _____ Controlled: Yes or No

Current medication(s), please list: _____

What was the date of the last alteration to dosage or type of medication: _____

Date of last seizure: _____ Current frequency of seizures: _____

Average duration: _____

Typical motor activity during the seizure: _____

Severity of motor activity during seizure (circle all that apply): Mild/Barely Noticeable Moderate Severe Complete Loss of Control

Is there a specific time or environment when seizures are likely to occur, (example: day, night, sleeping, with physical activity, etc.):

Is anything likely to prompt seizure activity (exercise, fatigue, heat, etc.): _____

Are there noticeable signs or an aura that signals the start of seizure activity: _____

A description of the participant's behavior during the post-ictal (recovery) state, and its duration: _____

Special instructions regarding what to do should a seizure occur at the center: _____

Please Print, Type or Stamp

Physician's Name (please print): _____ MD DO NP PA Other _____

Physician's Signature: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ License/UPIN Number: _____

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Physical and Occupational Therapy Evaluation

Please complete all applicable areas.

Date: _____

Participant's Name: _____ Date of Birth: _____ Age: _____

Reflexes: _____

Tone: _____

ROM: _____

Posture: _____

Balance: _____

Mobility: _____

Gait (*where applicable*): _____

Senses/Sensation: _____

Development Motor Sequence Activities (*where applicable*): _____

Communication: _____

Equipment/Aids: _____

ADL's: _____

Circulation: _____

Additional Notes: _____

Precautions: _____

Therapist's Signature (a registered PT or OT must sign)

I am currently not under the care of a PT or OT. I will notify you if that changes.

Participant, Parent, or Guardian's Signature

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