3701 Kidd Lane
Charlotte, NC 28216
704.393.0333
www.lifespanservices.org

2008-2009
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 $15 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 $25 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 accessed a $20 late fee.

We look forward to your participation in our program.

Sincerely,

The Staff at LifeSpan Farm – Therapeutic Riding Center

Warning: Under North Carolina Law, Chapter 99 E of the North Carolina General Statues, an equine activity sponsor or equine professional is not liable for an injure to or the death of a participant in equine activities resulting exclusively from the inherent risks of equine activities.

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

General Information

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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Medications (*Include prescription, over-the-counter; name, does and frequency.)*

____

____

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)
Signed in the presence of center staff

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)
Signed in the presence of center staff

Eligibility Verification

I certify that ______________________________ (Participant's name) meets the eligibility requirements outlined on page 1 of the Rider Registration Packet.

Signature: ____Date:________________________

Participant (Parent or Legal Guardian if participant is under the age of 18 yrs)
Signed in the presence of center staff

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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)
Signed in presence of center staff

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)
Signed in presence of center staff

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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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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.

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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: + --

Nuerological 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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Physical and Occupational Therapy Evaluation

Please complete all applicable area

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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