Raemelton
THERAPEUTIC EQUESTRIAN CENTER

569 SOUTH TRIMBLE ROAD – MANSFIELD, OHIO 44906
419.756.0040 – 419.756.6825 fax - www.raemelton.org

RAEMELTON EQUINE ACTIVITIES REGISTRATION

PARTICIPANT INFORMATION:

Date _____

_____ Last Name

_____ First Name

_____ Address

( )_____ Contact Phone Number

___ Y ___ N Can text be received to this number

_____ City

_____ State _____ Zip Code

Sex: F _____ M _____

_____ **Last 4 Digits** of Social Security Number

_____ Date of Birth

_____ **Height**

_____ **Weight** **(Riding Weight Limit 185 LB)**

Has participant previously participated in equine activities? _____

If yes, where and what type of activity? _____

Participant is a *(circle one)*: Minor Adult w/a legal guardian Independent adult

For demographic data only, please indicate participant's ethnic background. Check all that apply:
____ Caucasian _____ Asian _____ Hispanic/Latino ____ African American _____ Native American ____ Other ____ Prefer not to answer

PARENT/GUARDIAN & EMERGENCY CONTACT INFORMATION:

_____ Name

_____ Relationship

_____ Primary (Preferred) Phone Number

_____ Alternate Phone

Emergency Contact? Yes or No

_____ Name

_____ Relationship

_____ Primary (Preferred) Phone Number

_____ Alternate Phone

Emergency Contact? Yes or No

Does the participant have **LIFE THREATENING ALLERGIES** (meds, bee stings, latex, etc.): Yes _____ No _____
If yes, please list

_____

FOR MINOR RIDERS ONLY:

School presently attending: _____ Grade _____

Father's Name _____

Occupation _____

Business Phone _____

Cell Phone _____

Email _____

Mother's Name _____

Occupation _____

Business Phone _____

Cell Phone _____

Email _____

PROGRAM SELECTION **SESSION**

Therapeutic Riding ____ EFL _____ Camp _____ Spring ____ Summer ____ Fall _____ Winter _____

PAYMENT OPTIONS : Must check mark one

_____ **Option 1: Full Session Payment**
Therapeutic Riding or EFL (10wk) $325.00 _____ EFL **Winter only** (6 wk)$195.00 _____
Camp (6 half day sessions) $325.00 _____

If Agency Pays, **please list here**: _____

_____ **Option 2: Three Equal Payments**
Therapeutic Riding, EFL or Camp $109/$109/$107_____ EFL Winter (6wk) $65/$65/$65_____
(First payment due prior to the start of session, remaining due on the 4th and 8th classes)

_____ **Option 3: Rider Scholarship**
A financial aid application must be filled out for eash session
Acceptance of full or partial scholarships are based on the Review Committee approval of the Scholarship Application

AN ANNUAL MEDICAL HISTORY & PHYSICIAN STATEMENT MUST BE COMPLETED AND SIGNED ANNUALLY BY A MEDICAL PROFESSIONAL FOR ALL MOUNTED ACTIVITIES.

The medical history and physician statement is included in this packet and all information on the statement must be filled out **only** by the physician and directly faxed. Participants with Down syndrome, see Physician's Release page for Participants with Down syndrome for more information.

A REGISTRATION PACKET MUST BEFILLED OUT EACH YEAR.

PHOTO RELEASE

I hereby consent to and authorize the use and reproduction by Raemelton Therapeutic Equestrian Center of any and all photographs and any other audiovisual materials taken of me, my son or daughter or my ward for promotional printed materials, educational activities or for any other use for the benefit of Raemelton Therapeutic Equestrian Center's program(s). _____**Consent** _____**Do Not Consent**

_____ _____ _____
Signature Relationship to Rider Date

DECLARATION OF INTENT

I hereby acknowledge that the aforementioned Rider is applying for acceptance into a Riding Program at Raemelton Therapeutic Equestrian Center. I have a completed and signed Liability Waiver and Emergency Medical Forms for this Rider. I understand that participation in this Program is dependent upon compliance by the Rider with all policies, procedures and safety requirements of the Equestrian Center. Failure to comply may result in dismissal from the Program.

The appropriate program selection and desired method of payment are indicated in this document. I agree that I will be responsible for the cost of the selected program. Payment options and/or any financial assistance for which this Rider qualifies will be arranged by me and approved by the Raemelton Therapeutic Equestrian Center staff prior to the start of the session.

My signature herein indicates my acceptance of the above-specified stipulations. If the Rider is a minor, permission is also granted for full participation in any and all activities related to the selected Program.

_____ _____ _____
Signature Relationship to Rider Date

RAEMELTON THERAPEUTIC EQUESTRIAN CENTER

WAIVER OF LIABILITY AND CONSENT FOR INDIVIDUALS TO PARTICIPATE IN RAEMELTON THERAPEUTIC EQUESTRIAN CENTER PROGRAMS

I hereby grant consent for the undersigned Equine Activity Participant (as such term is defined in Ohio Revised Code 2305.321, Section A(3) and referred herein as "Participant") to participate in the Raemelton Therapeutic Equestrian Center program.

In addition, this document constitutes a written Waiver of Liability, as defined and described in Ohio Revised Code 2305.321, Sections C(1) and C(2), for the benefit of the Raemelton Therapeutic Equestrian Center, Inc., its Affiliates and its duly Authorized Agents. Pursuant to Ohio Revised Code 2305.321, section C(2)a, the undersigned acknowledge that there are inherent risks associated with Equine Activities including, but not limited to:

- ✓ The property of an Equine to behave in ways that may result in injury, death or loss to persons on or around the Equine;
- ✓ The unpredictability of an Equine's reaction to sounds, sudden movement, unfamiliar objects, persons or other animals;
- ✓ Hazards including but not limited to, surface or subsurface conditions;
- ✓ A collision with another Equine, another animal, a person or an object;
- ✓ The potential of an Equine Activity Participant to act in a negligent manner that may contribute to injury, death or loss to the person of the participant or to other persons, including but not limited to, failing to maintain control over an Equine or failing to act within the ability of the Participant.

I have read and understand the above inherent risks, have had the opportunity to have my questions answered, and understand the potential benefits and alternatives to this activity.

_____ _____
Participant's Signature Date

_____ _____
Participant's Printed Name Participant's Date of Birth

Please complete section below if Participant is a Minor or under Guardianship.

_____ _____
Parent/Guardian Signature (If different from authorized signature) Date

_____
Parent/Guardian Printed Name

_____ _____ _____
Authorized Signature Date

_____
Authorized Person's Printed Name & Title

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For therapeutic riding and camp only

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ANNUAL MEDICAL HISTORY & PHYSICIAN STATEMENT

TO BE COMPLETED ANNUALLY **ONLY BY A LICENSED MEDICAL PROFESSIONAL AND FAXED DIRECTLY TO 419.756.6825**
Parents/Guardians **DO NOT** fill in any information on this form.

Participant's Name _____ Date of Birth _____

Height _____ Weight _____ Tetanus Shot: Yes or No When? _____

Diagnosis/Disability _____ Date of Onset _____

Seizures: Yes _____ No _____ If yes, what type? _____

Date of last seizure _____ Frequency of seizures _____

Please indicate if the patient has had a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please explain in comments section.

AREAS	YES	NO	COMMENTS
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Psychological Impairment			
Learning Disability			
Mental Impairment			
Other			

Please list all medical devices (feeding tubes, shunts, etc.):

_____

_____

Does Participant have *(please circle one for each)*:

Asthma Inhaler	Yes	or	No	Crutches	Yes	or	No
EpiPen	Yes	or	No	Braces	Yes	or	No
Wheelchair	Yes	or	No	Walker	Yes	or	No

In the past 12 months, has the participant *(please circle one for each)*:

Been hospitalized for any serious injury, condition or surgery?	Yes	or	No
Experienced loss of consciousness, including seizures?	Yes	or	No
Experienced a psychotic crisis?	Yes	or	No
Had necessary restrictions to activities for medical reasons?	Yes	or	No

If yes, please explain: _____

SPECIAL PRECAUTIONS

The following conditions, although do not necessarily restrict a participant from therapeutic riding, can represent precautions or contraindications to the benefits of therapeutic riding.
Therefore, when completing this form please note whether these conditions are present and to what degree.

ORTHOPEDIC
Spinal Fusion or Abnormalities
Atlantoaxial Instabilities (Down Syndrome)
Scoliosis, Kyphosis, Lordosis
Hip Subluxation or Dislocation
Osteoporosis
Pathologic Fractures
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

NEUROLOGICAL
Hydroencephalus/Shunt
Spina Bifida
Tethered Cord
Hydromyelia
Paralysis or Spinal Cord Injury
Seizure Disorder

MEDICAL/SURGICAL
Allergies
Cancer
Poor Endurance
Recent Surgery
Peripheral Vascular Disease
Hemophilia
Serious Heart Condition

SECONDARY CONCERNS
Under Age of Four Years
Acute Exacerbation of Chronic Disorder
Indwelling Catheter

Please indicate any special precautions: _____

_____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Raemelton Therapeutic Equestrian Center will weigh medical information above against the existing precautions and contraindications. I concur with a review of the person's abilities/limitations by a licensed/credentialed health professional in the implementing of an effective therapeutic equestrian program.

_____ _____
Physician's SIGNATURE Physician's PHONE

_____ _____
Physican's PRINTED NAME DATE

_____
ADDRESS/STAMP

_____ _____ _____
CITY STATE ZIP

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Participants with Down Syndrome:

An annual medical clearance from a licensed Physician that includes a neurological exam that specifically denies any symptoms consistent with atlantoaxial instability (AAI) must be obtained prior to starting mounted activities. The medical examination including the complete neurologic exam showing no evidence of AAI from the Physician must be completed annually for continued participation in mounted activities. New participants must have a current cervical x-ray that will be valid for 3 years from exam date. Current participants that have a cervical x-ray on file is valid for 3 years from exam date.

PHYSICIAN'S RELEASE

Participant's Name_____ Date of Birth _____

Cervical X-ray for Atlantoaxial Instability: POSITIVE NEGATIVE	
X-Ray Date:	

MEDICAL **Normal**	**IF ABNORMAL, PLEASE EXPLAIN**
Neurologic	
MUSCULOSKELETAL	
Neck	
Back	
Upper Extremities	
Lower Extremities	
Does this patient have symptoms consistent with atlantoaxial instability? Yes No DATE OF EXAM:_____	

PHYSICIAN'S RELEASE

I have examined the above-named participant and, given the participant's diagnosis and health history, this person does not present apparent clinical contraindications and is asymptomatic of AAI for equine sports. I understand that Raemelton Therapeutic Equestrian Center will weight the medical information provided against the existing precautions and contraindications; therefore, I refer this person to Raemelton Therapeutic Equestrian Center for ongoing evaluation to determine eligibility for participation.

Physician's Signature_____ Date _____

Physician's Name (**Please Print**)_____ Phone_____

Address/City/Zip_____

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PARTICIPANT ASSESSMENT and GOAL CHECKLIST

To be completed by participant, parent, guardian, teacher or therapist.

Participant's Name _____ Age: _____

Disability _____

Please describe the following that apply

Cognitive Disability _____

Physical Disability _____

Hearing Loss (Mode of Communication) _____

Speech _____

Vision _____

Ambulatory _____

Emotional/Behavioral Disability _____

Fears _____

Behaviors to encourage/discourage _____

Aggression _____

Other _____

Does the participant have a history of seizures? _____ Date of last seizure?_____

What type of seizure does participant experience?_____

Frequency of seizures? _____

***Please note**: if the participant has not been seizure free for a period of 12 months you- MUST -fill out the Seizure Evaluation Form included in this packet.*

Does the participant have any unique issues (behavioral, social, etc.), how do you prefer to handle typical situations? Please include methods of behavior modification, communication and anything else that may be pertinent to the instructor working with this participant.

_____

_____

_____

To assist our instructors in formulating their lesson plans, please mark 3 items in each category which you/your child would like to work toward developing. Please prioritize items with #1 being the most important goal.

PHYSICAL GOALS

___ Improved Balance
___ Improved Posture
___ General Coordination
___ Eye/Hand Coordination
___ Head Control
___ Trunk Control
___ Strength
___ Gross Motor Skills
___ Fine Motor Skills
___ Decrease Tactile Defensiveness
___ Muscle Tone
___ Increased Range of Motion
___ Sensory Integration
___ Endurance
___ Visual/Spatial Orientation

SOCIAL/RECREATIONAL GOALS

___ Socialization
___ Cooperation
___ Sportsmanship
___ Enjoyment
___ Confidence/Self Esteem
___ CommunicationSkills
___ Attention
___ Responsibility
___ Self-Sufficiency
___ Social Skill Development
___ Teamwork
___ Respect
___ Independence
___ Trust
___ Interpersonal Relationships

COGNITIVE/EDUCATIONAL GOALS

___ Color Recognition
___ Shape Recognition
___ Verbalization
___ Vocabulary Expansion
___ Sequencing
___ Spatial Awareness
___ Reading Skills
a. Letter Recognition
b. Word Recognition
c. Basic Sentences
___ Number Recognition

Please list one goal the participant is working on _____

_____

What is the participant hoping to learn from this experience _____

_____

_____

COMPLETED BY

Name _____

Relationship to Participant_____

Address _____

City _____ **State** _____ **Zip** _____

Phone _____

SEIZURE EVALUATION FORM

If participant has **experienced seizure activity within the past 12 months**, this **SEIZURE EVALUATION FORM IS REQUIRED**.

Consultation with the participant's physician is recommended when completing this form.

To Participants/Parents/Guardians/Treating Physicians: Please complete this form including as much information as possible. Riding and working around horses is an at risk activity. Health conditions that increase that risk need to be carefully analyzed. The safety of all participants, volunteers and horses is our utmost priority and careful consideration of all involved is mandatory.

_____
Participant Name

_____ ( )_____
Physician Treating Seizures — Physician's Phone

_____ _____
Date(s) of last seizure(s) — Type(s) of last seizure – please list all

_____ _____
Frequency of seizure(s) — Duration of each seizure

_____
Typical cause(s) of seizure activity, if known

Seizure activity indicator(s) – aura, behaviors or manifestations of oncoming seizure activity_____

_____

_____ Is the participant able to express when a seizure may occur? _____

_____
After effects of seizure

During a seizure, I/my child/patient may:

- ❑ Stare briefly
- ❑ Walk around
- ❑ Perform aimless activities
- ❑ Suddenly cry / fall / become rigid, followed by muscle jerks / saliva on lips / bluish skin color
- ❑ Experience loss of bladder or bowel control
- ❑ Be confused, have a headache, be fatigued; followed by full return to consciousness
- ❑ Other, please explain: _____

_____ _____ _____
Participant's/Parent's/Guardian's Signature — **Relationship to Participant** — Date

_____
Participant's/Parent's/Guardian's Printed Name