



**Colorado Therapeutic Riding Center, Inc.**  
11968 Mineral Road, Longmont, CO 80504  
(303) 652-9131 FAX (303)652-2072 [www.ctrcinc.org](http://www.ctrcinc.org)

**Dear Prospective Participant:**

Thank you for your interest in the Colorado Therapeutic Riding Center (CTRC). Enclosed please find a participant application and a physician statement form. The first step toward participating in a CTRC session is to complete and return these forms. You complete the application, and your physician completes the Medical History form. The forms can be faxed or mailed to me. Once I have received both forms, I will contact you to schedule an evaluation. The cost of the evaluation is \$25 dollars. If I determine that we need a physical or occupational therapist present at the evaluation, an additional \$45 dollar fee will be added.

During the 45-minute evaluation, we will ensure that our program is appropriate for you and that there are no contraindications to your participation. We will discuss our services to determine what is right for you and we will discuss your goals. We will also conduct a brief mounted evaluation on the horse. Following the evaluation, you will be eligible to register for our next riding session on a "first come, first serve" basis. Please see the enclosed Service and Fee schedule for costs and session dates.

CTRC strives to provide the safest possible conditions for participants, volunteers and employees. The acceptance, and continued participation, of a participant in our program depends on the availability of instructors, volunteers and suitable horses and is based on our determination that we can safely accommodate the participant. CTRC adheres to precautions and contraindications for participants established by the North American Riding for the Handicapped Association. CTRC retains the right to refuse any participant that we cannot safely accommodate. Participants must inform us of changes in health status. CTRC requires annual updates of the Medical History Form.

Please note the following CTRC policies:

- 1 Lessons are canceled in the event of hazardous conditions (e.g. extremely cold weather, unsafe driving conditions). CTRC does not refund money for classes missed due to circumstances beyond our control.
- 2 CTRC does not refund money for classes that you must cancel.
- 3 Please give as much advance notice as possible if you will miss a class, so we can cancel volunteer(s) and not tack up your horse.
- 4 The length of a lesson includes time for mounting and dismounting.
- 5 Rider weight limit is 200 lbs.
- 6 Our horses and volunteers should be treated kindly – they work so hard for us all.
- 7 When near/on horses, participants must wear ASTM-approved riding helmets, which CTRC supplies.
- 8 Participants should wear appropriate clothing, e.g. closed-toe shoes (heels if possible) and long pants.
- 9 Parents/caregivers/siblings must wait in designated areas.
- 10 No smoking on property.
- 11 No pets.
- 12 Please drive slowly and park in designated areas.
- 13 Talk with your instructor or me about any concerns or suggestions – sooner rather than later, please.
- 14 Have FUN!

Directions to CTRC are on the back of this letter. Thank you again for your interest in our program. I hope to meet you soon.

Sincerely,  
*Mary Mitten*

Mary Mitten  
Program Coordinator



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## PARTICIPANT APPLICATION

**In order to ensure coordinated care, CTRC staff and volunteers are provided with information about participant's abilities/disabilities.**

Participant's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Male  Female  Race/Ethnicity \_\_\_\_\_ (optional)  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_  
School Name \_\_\_\_\_  
Parent or Guardian Name(s) \_\_\_\_\_  
Rider or Guardian's Employer \_\_\_\_\_

List Phone Numbers and whose number it is, if other than Participant:

Home # \_\_\_\_\_ If not Participant's #, whose is it? Name: \_\_\_\_\_  
Work # \_\_\_\_\_ If not Participant's #, whose is it? Name: \_\_\_\_\_  
Cell # \_\_\_\_\_ If not Participant's #, whose is it? Name: \_\_\_\_\_

How did you hear of our program? \_\_\_\_\_

### **Please describe limitations/concerns in these areas:**

Physical function (e.g. ambulation, motor skills, balance, strength, tone, vision):

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Cognition and Processing (e.g. attention, touch/sensation, memory, speech and language, sensory integration, learning disabilities, developmental delays):

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Psychological, emotional, behavioral, social issues:

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Do you have previous riding experience? If so, please describe:

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## PARTICIPANT'S CONSENT & RELEASE FORM

### CONSENT FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury while participating in the services of, or while being on the property of, the Colorado Therapeutic Riding Center (CTRC), I authorize CTRC to secure and retain medical treatment and/or transportation if needed. This authorization includes any treatment deemed necessary by a treating health care professional and includes but is not limited to x-ray, surgery, hospitalization, and medication. In addition, I authorize CTRC to release my/my child/my ward's records to any individual involved in medical treatment and/or necessary transportation.

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

In case of emergency, contact \_\_\_\_\_ Phone \_\_\_\_\_

or contact \_\_\_\_\_ Phone \_\_\_\_\_

or contact \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Health Insurance Name (optional) \_\_\_\_\_ Policy # \_\_\_\_\_

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

(or signature of parent/guardian if participant is under age 18)

**LIABILITY RELEASE:** Under Colorado Law, an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to section 13-21-119, Colorado Revised Statutes.

\_\_\_\_\_(Participant's name) would like to participate in the Colorado Therapeutic Riding Center's (CTRC) program. I acknowledge the risks and potential for risks in riding and working with horses. However, I feel that the possible benefits to myself/my child/my ward are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs, assigns, executors and/or administrators, waive and release forever all claims for damages against CTRC, its Board of Directors, Advisory Board, Instructors, Therapists, Aides, volunteers, employees, agents, and representatives of any kind for any and all injuries, damages, claims, demands, causes of actions, law suits, and/or losses I/my child/my ward may sustain while participating in CTRC's program.

Date \_\_\_\_\_ Participant's Signature \_\_\_\_\_

(or signature of parent/guardian if participant is under age 18)

**PHOTO & PUBLICITY RELEASE (Optional):** I hereby consent to and authorize the Colorado Therapeutic Riding Center to use my/my child's/my ward's name in all audio, visual and written promotional material and to use and/or reproduce any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.

Date \_\_\_\_\_ Participant's Signature \_\_\_\_\_

(or signature of parent/guardian if participant is under age 18)



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**Dear Health Care Provider:**

Your patient is interested in participating in supervised equine activities. In order to safely provide this service, we request that you complete (or update) the attached Participant Medical History one-sided form. 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 Instability – include neurologic symptoms  
Coxa Arthrosis  
Cranial Deficits  
Heterotopic Ossification/Myositis Ossificans  
Joint Subluxation/dislocation  
Osteoporosis  
Pathologic Fractures  
Spinal Fusion/Fixation  
Spinal Instability/Abnormalities

**Neurologic**

Hydrocephalus/Shunt  
Seizure  
Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia

**Medical/Psychological**

Allergies  
Animal Abuse  
Physical/Sexual/Emotional Abuse  
Blood Pressure Control  
Dangerous to self or others  
Exacerbations of medical conditions  
Fire Setting  
Heart Condition  
Hemophilia  
Medical Instability  
Medications – e.g. photosensitivity  
Migranes  
PVD  
Poor Endurance  
Respiratory Compromise  
Recent Surgeries  
Skin Breakdown  
Substance Abuse  
Thought Control Disorders  
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine activities, please contact me at (303) 652-9131.

Sincerely,  
*Mary Mitten*

Mary Mitten  
Program Coordinator



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## PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN STATEMENT

To be completed by physician

Participant's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Home Phone # \_\_\_\_\_

Name of Parent(s)/Guardian(s) \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Medications \_\_\_\_\_

**Mobility:** Independent Ambulation  **OR** Assisted Ambulation: Braces  Crutches  Walker  Wheelchair

**Special Precautions:**

Seizures: Yes  No  Seizure Type \_\_\_\_\_ Date of Last Seizure \_\_\_\_\_ Now Controlled? Yes  No

Shunt: Yes  No  Date of last revision \_\_\_\_\_

Down Syndrome: Atlanto Dens Interval X-rays, date \_\_\_\_\_ Result + ---

Any Neurologic Symptoms of Atlanto Axial Instability? \_\_\_\_\_

**Primary** Diagnosis/Presenting Concern \_\_\_\_\_ Date of Onset \_\_\_\_\_

**Secondary** Diagnosis/Presenting Concern \_\_\_\_\_

**Please list current or past indications/special needs in the following areas, including surgeries:**

AREAS	YES	NO	COMMENTS
Visual			
Auditory			
Tactile Sensation			
Speech & Language			
Cognitive/Processing			
Learning & Development			
Psychological/Emotional/Behavioral			
Muscular			
Balance			
Orthopedic – Note Scoliosis or Hip Subluxation/Dislocation			
Neurologic			
Cardiac			
Circulatory			
Pulmonary			
Integumentary/Skin			
Immunity			
Pain			
Allergies			
Other			

*To my knowledge, there is no reason this person cannot participate in supervised equestrian activities. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional, as necessary, in the implementation of an effective equine activity program.*

**Date** \_\_\_\_\_ **Name & Title (print)** \_\_\_\_\_ MD DO NP PA

**Signature** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_