



Colorado Therapeutic Riding Center, Inc.
11968 Mineral Road, Longmont, CO 80504
(303) 652-9131 FAX (303)652-2072 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 \$45 dollars.

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 _____

Email address: _____

School Name _____

Parent or Guardian Name(s) _____

Rider or Guardian's Employer _____

Diagnosis: Primary _____ Secondary _____

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? _____

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

Physical skills

Is the participant proficient in the following skills? Mark X for yes:

<input type="checkbox"/>	Sits unassisted
<input type="checkbox"/>	Stands independently
<input type="checkbox"/>	Walks unassisted
<input type="checkbox"/>	Runs unassisted

<input type="checkbox"/>	Uses hands independently
<input type="checkbox"/>	Releases object
<input type="checkbox"/>	Bears weight on hands

<input type="checkbox"/>	Uses bathroom independently
<input type="checkbox"/>	Climbs stairs
<input type="checkbox"/>	Bears weight on legs

Describe General Balance: _____

Please list and explain ANY assistive devices that the participant may use at home or school:

Notes on Hearing or Vision Impairments: _____

Hand Preference: Left Right No Preference

Sensory

Please describe any sensitivities in the following areas:

Visual (seeing): _____

Auditory (hearing): _____

Olfactory (smelling): _____

Tactile (touching): _____

Proprioceptive (movement): _____

Cognition and Processing:

No Concerns (If there are no concerns in any of the following areas, please skip ahead to Personality Profile)

If there are concerns in the area of cognition and processing, please complete the following:

Is the participant proficient in the following skills? Mark X for yes:

EDUCATIONAL/COGNITIVE	
<input type="checkbox"/>	Knows numbers
<input type="checkbox"/>	Knows letters
<input type="checkbox"/>	Knows left/right
<input type="checkbox"/>	Knows prepositions
<input type="checkbox"/>	Communicates feelings
<input type="checkbox"/>	Makes choices

SOCIAL	
<input type="checkbox"/>	Recognizes name
<input type="checkbox"/>	Makes eye contact
<input type="checkbox"/>	Waves/ says hello/bye
<input type="checkbox"/>	Shares toys/items
<input type="checkbox"/>	Knows safety awareness
<input type="checkbox"/>	Interacts with peers
<input type="checkbox"/>	Appropriate conversation
<input type="checkbox"/>	Takes turns

LANGUAGE	
<input type="checkbox"/>	Makes sounds
<input type="checkbox"/>	Says words
<input type="checkbox"/>	Combines 2 or more words
<input type="checkbox"/>	Speaks in complete sentences
<input type="checkbox"/>	Understands "No"
<input type="checkbox"/>	Letter sound identification
<input type="checkbox"/>	Signs or uses gestures
<input type="checkbox"/>	Uses picture symbols

Follows Direction: 1 Step ___ 2 Step ___ 3 Step ___ Complex ___

Attention to task: Poor (0-1 min) ___ Fair (1-5 min) ___ Avg (5 min) ___

Frustration Tolerance: Poor ___ Fair ___ Avg ___

Problem Solving: Poor ___ Fair ___ Avg ___

Personality Profile

Please describe personality and strengths: _____

What are some favorite activities or topics? _____

What are some fears or dislikes? _____

Psychological, emotional, behavioral, social issues: _____

Learning Style, please circle: Visual/learns by seeing Auditory/learns by hearing Kinesthetic/learns by doing

Successful Intervention Strategies used (sensory modalities, behavioral, rewards, etc.):

Our Family's Do's and Don'ts: _____

Any other special things we should know?

Please list any goals (i.e. what would you like to accomplish in therapeutic riding/hippotherapy?):

This form was completed by (participant/parent/other): _____

*Please attach additional sheets of paper or more information (i.e. IEP) if desired

*Feel free to enclose a photo for your file



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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** _____