Colorado Therapeutic Riding Center, Inc.
11968 Mineral Road, Longmont, CO 80504
PHONE: (303)652-9131 FAX: (303)532-0164 www.ctrcinc.org

Dear Prospective Participant:

Thank you for your interest in the Colorado Therapeutic Riding Center (CTRC). A 501(c)(3) non-profit organization and a premier accredited center by PATH Intl, CTRC has been providing therapeutic riding and other equine assisted activities to individuals with therapeutic needs in the Denver-Metro area since 1980.

Please complete and return via email, fax or US mail the enclosed application (you complete the Participant Application, Participant Consent and Release form and your physician completes the Medical History/Physician Statement). We schedule an on-site visit/evaluation after we receive your application and believe that we may have suitable openings in our schedule. The evaluation is an opportunity to determine if our services are a good fit and whether we can safely accommodate you/your son or daughter. There is no fee for therapeutic riding evaluations; hippotherapy evaluations require direct payment to the therapist.

Most participants pay privately for CTRC services. If you are planning to pay with outside agency funds or CES Medicaid Waiver funds, please talk first with your case manager to be sure the funding can be authorized for therapeutic riding and/or hippotherapy. CTRC does not bill private insurance but our therapists can provide you with documentation. Therapeutic riding is not covered through private insurance/Medicaid. We can provide you with documentation if you believe that a flexible spending account or health care spending account covers therapeutic riding or hippotherapy expenses (again, you would need to submit this documentation on your own).

In order for everyone to get the most out of their experiences at CTRC we strive to provide the safest possible conditions and adhere to precautions and contraindications for participants established by PATH Intl. Please review the following CTRC policies:

1. The acceptance and continuation of a participant depends on the availability of instructors, volunteers and suitable horses.
2. Rider weight limit is subject to CTRC's Height/Weight policy and horse availability (**200 pound maximum**).
3. CTRC retains the right at any time to refuse any participant that we cannot safely accommodate.
4. We ask participants to inform us of any changes in health status.
5. An annual update of the Medical History Form/Physician Statement is required.
6. When near/on horses, participants must wear ASTM-approved riding helmets, which CTRC supplies.
7. Appropriate clothing, e.g. closed-toe shoes (heels if possible) is required.
8. CTRC does not offer make-ups or refunds for missed classes, including classes that we must cancel due to hazardous weather.

When driving to CTRC, please use caution pulling into CTRC from Highway 52 as other drivers may not be anticipating your turn. When heading westbound (turning left into CTRC), we would advise you to continue past CTRC and the Tree Farm until you come to the left turn lane onto County Road 119. You can then turn around and head back eastbound and turn right into CTRC.

Thank you again for your interest in our programs!

Sincerely,

Michele Bruhn
Head Instructor
headinstructor@ctrcinc.org

Date Received:_____Received by (Initials):_____

Colorado Therapeutic Riding Center, Inc.
11968 Mineral Road, Longmont, CO 80504
PHONE: (303)652-9131 FAX: (303)532-0164 www.ctrcinc.org

PARTICIPANT APPLICATION

In order to ensure coordinated care, staff and volunteers are provided with information about abilities/disabilities.

Participant's Name _____ Date of Birth _____ Age _____

Gender _____ Height _____ Weight _____ Race/Ethnicity(optional) _____

Street _____City_____ State ___ Zip ____ County _____

Email address:_____

School Name _____Grade_____

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:

Cell 1 # _____ If not Participant's #, whose is it? Name: _____

Cell 2 # _____ If not Participant's #, whose is it? Name: _____

Other # _____ If not Participant's #, whose is it? Name: _____

How did you hear of our program? _____

Are you interested in:

Therapeutic Riding ☐ Hippotherapy ☐ Interactive Vaulting ☐ Miniature Horse Visit ☐

Will you be paying:

- ☐ Own funds/ using private insurance/ flexible/ health spending account
- ☐ Agency/ Government Funding:

  List agency name:_____

  List funding type:_____

  List case manager:_____

Please check your primary area(s) of interest while at CTRC and share your goals.

☐ Equestrian/horsemanship (goals _____)

☐ Therapeutic (goals _____)

☐ Recreational (goals _____)

☐ Social (goals _____)

☐ Other_____

Describe previous riding experience, if any:_____

_____

Experience wearing a helmet (e.g. ski, bike) _____

I believe that wearing a helmet will☐ or will not☐ be a possible challenge (if so, please practice prior to eval).

Physical skills

Is the participant able to demonstrate the following skills? Mark X for yes:

	Sits unassisted
	Stands independently
	Walks unassisted
	Runs unassisted

	Moves sideways (laterally)
	Uses hands independently
	Releases objects
	Skip
	Hop

	Uses bathroom independently
	Climb stairs
	Bears weight on legs
	Stand on one foot

Describe general balance: _____

Describe muscle tone: _____

Please list and explain ANY assistive devices that the participant may use at home or school (e.g. walker, communication device):

_____

Notes on Hearing or Vision Impairments: _____

Is the participant able to demonstrate the following skills? Mark X for yes:

EDUCATIONAL/COGNITIVE

	Knows numbers
	Knows letters
	Knows left/right
	Recognizes names
	Displays safety awareness
	Makes choices

SOCIAL

	Recognizes name
	Makes eye contact
	Waves/ says hello/bye
	Shares toys/items
	Communicates feelings
	Interacts with peers
	Converses with others
	Takes turns

LANGUAGE

	Makes sounds
	Says words
	Combines 2 or more words
	Speaks in complete sentences
	Understands "No"
	Letter sound identification
	Signs or uses gestures
	Uses picture symbols

Please describe personality and strengths: _____

_____

Psychological, emotional, behavioral, social issues: _____

_____

_____

Any other special things we should know? _____

_____

_____

Please list all times that MIGHT work to participate in CTRC programs: _____

_____

_____

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

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

***Please enclose a photo for your file**

Colorado Therapeutic Riding Center, Inc.
11968 Mineral Road, Longmont, CO 80504
PHONE: (303)652-9131 FAX: (303)532-0164 www.ctrcinc.org

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)

Colorado Therapeutic Riding Center, Inc.
11968 Mineral Road, Longmont, CO 80504
PHONE: (303)652-9131 FAX: (303)532-0164 www.ctrcinc.org

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 or headinstructor@ctrcinc.org.

Sincerely,
Michele Bruhn
Michele Bruhn
Head Instructor

Colorado Therapeutic Riding Center, Inc.
11968 Mineral Road, Longmont, CO 80504
PHONE: (303)652-9131 FAX: (303)532-0164 www.ctrcinc.org

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN STATEMENT *(Physician Completes)*

Participant's Name _____ Date of Birth _____

Address _____ Best Phone # _____

Name of Parent(s)/Guardian(s) _____

Height _____ **Weight** _____ Relevant Medications _____

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

Special Precautions:
For Down Syndrome, this box must be checked: ☐ As the physician, I have conducted a medical examination including a complete neurologic exam within the past year that shows no evidence of Atlanto Axial Instability or Focal Neurologic Disorder (Comments:_____)

Seizures: Yes ☐ No ☐ Seizure Type _____ Date of Last Seizure _____
Changes to Seizure Activity in the past year? Yes ☐ No ☐ Now Controlled? Yes ☐ No ☐

Scoliosis: Yes ☐ No ☐ Degree of Scoliosis: _____

Shunt: Yes ☐ No ☐ Date of Last Revision _____

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* _____