Back Bay Therapeutic Riding Club Inc.

20262 Cypress Ave. Newport Beach, CA 92660
949-474-7329 www.backbaytrc.org

BACK BAY THERAPEUTIC RIDING CLUB
RIDER REGISTRATION/HEALTH HISTORY/RIDER PROFILE
(UPDATED ANNUALLY)

Name of Participant: ____________________________________

Parents/Guardian (if applicable): ____

Address: ________________________________City: ____________________ Zip: __________

Home Phone:__________________________ Cell Phone: ________________________________

Emergency Contact: _____________________________________ Phone: __________________

Parent Occupation and Employer:
Father: ____ Phone:___________________
Mother:____Phone:___________________

Rider:
Participant Occupation/School and Level: ____
Participant DOB: ____/_____/_______ Sex: ______ Height: ____________ Weight: ______________

Diagnosis: ____ Date of Onset: ____________

Hospitalization/Surgery (date & reasons): ____
____

Past Health History: ____
____

Recent Changes in Health History: ____
____

Is a seizure disorder present? ☐No ☐ Yes, seizure type: _____________ Date of last seizure: _________

Other therapies (type and frequency):____
____

Communication: ☐ verbal ☐ non-verbal, communication methods: ____________________________
Behavior issues: ____
____

Medications (current): ____
____

Precautions/restrictions:____

____

____

Rider's life goals (examples : improve walking, speaking, self-esteem, having friends, recreation, sport, stretching, ride a bike, be independent, distinguish right from left, sense of safety, decrease anxiety, get dressed him/herself, learn alphabet, count, find a job, etc.)

Short-term goals:____

Long-term goals: ____

____ ____/_______/______

Signature of parent, participant or guardian Date

To be filled by BBTRC instructor:

Recommended horse(s): ____

Tack and equipment:

Helmet (*has to be ASTM-SEI approved for equestrian use*) : ☐ Own, if not, center's # or size:____________

Saddle: ☐ pad+surcingle ☐ English saddle ☐can ride both

Reins: ☐ halter+reins ☐ regular bridle

Ability level (circle appropriate skill level):

Mount: ☐croup ☐crest ☐other:
From the: ☐ ramp ☐ground
Assistance needed:

Dismount: ☐croup ☐crest ☐other:
To the: ☐ ramp ☐ground

Sitting trot:	introduced	in progress	mastered	comments:_______________________________
Posting trot:	introduced	in progress	mastered	comments:_______________________________
Diagonals:	introduced	in progress	mastered	comments:_______________________________
Canter:	introduced	in progress	mastered	comments:_______________________________
Steering/reins:	introduced	in progress	mastered	comments:_______________________________

Volunteer needs:

Walk only:	none	spotter	leader	1sidewalker	2sidewalkers
Walk/trot:	none	spotter	leader	1sidewalker	2sidewalkers

Additional specific skills learned : ____

Games played in lessons, favorite ones: ____

Additional information: ____

____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Print Participant Name ______________________________Date Of Birth____________
Print Parent/Guardian Name (If Applicable)_________________________________
Address ____
City _______________________________________ State ________ Zip_____________
Home Phone _________________________ Work Phone__________________________
In The Event I Cannot Be Reached:
Contact ____ Phone __________________
Alternate Contact ___________________________________ Phone __________________
Physician's Name ___________________________________ Phone __________________
Preferred Medical Facility ____________________________ Phone __________________
Health Insurance Co. _________________________________ Phone __________________
List all pertinent medical information (allergies to food or drugs, medications being taken, special medical conditions: ____

____

____

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 the agency, I authorize the **BACK BAY THERAPEUTIC RIDING CLUB, INC.,** 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 listed is unable to be reached.

DATE ____________ CONSENT SIGNATURE ________________________________
Print Name and Relationship____

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 **BACK BAY THERAPEUTIC RIDING CLUB, INC.,** In the event emergency treatment/aid is required, I wish the following procedures to take place:

____

____

____

DATE____________ CONSENT SIGNATURE_________________________________
Print Name and Relationship____

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RELEASE AND HOLD HARMLESS AGREEMENT

The program at the **BACK BAY THERAPEUTIC RIDING CLUB, INC.** provides therapeutic horseback riding for disabled children and adults. Volunteers and horses are carefully selected and trained and safety equipment is required for all riders since horseback riding is a risk exercise.

No student will be accepted for riding instruction and no volunteer accepted for service until this form has been **READ, UNDERSTOOD, COMPLETED AND SIGNED** by the parent(s) or guardian(s) of a minor, or if the student or volunteer is of legal age and sound mind, by the student or volunteer.

Although participation in the program is under strict supervision and every effort is made to avoid injury or accident, the undersigned acknowledges the inherent risks involved in riding and working around horses. This includes bodily injury from horseback riding or being in close proximity to horses. Among other risks, both horse and rider can be injured in normal use or in competition and schooling. In order to provide this valuable service, **NO LIABILITY** can be accepted by the **BACK BAY THERAPEUTIC RIDING CLUB, INC.** or any of the organizations or persons connected with the above named facility.

IN CONSIDERATION, for the privilege of riding and/or working around horses at the **BACK BAY THERAPEUTIC RIDING CLUB, INC.,** the undersigned, as self, or as parent(s) or guardian(s) of the undersigned minor, jointly and severally, do hereby agree to release, hold harmless and indemnify the **BACK BAY THERAPEUTIC RIDING CLUB, INC.,** its officers, directors, trustees, agents, employees, representatives, successors and assigns, from all manner of liability, loss, costs, claims, demands and damages of every kind and nature whatsoever, including but not limited to reasonable attorneys fees, which the undersigned or said minor may now or in the future have against the **BACK BAY THERAPEUTIC RIDING CLUB, INC.,** its officers, directors, trustees, agents, employees, representatives, successors and assigns, on account of any accident, damage, injury or illness, physical or mental condition, known or unknown, to the undersigned or said minor, or the treatment thereof, arising as a result of, or in any way connected to acts or incidents occurring at or relating to the **BACK BAY THERAPEUTIC RIDING CLUB, INC.,** it's officers, directors, trustees, agents, employees, representatives, successors or assigns, including but not limited to their negligence or gross negligence in rendering the services described above or in anyway incidental thereto.

Date_________Participant Name (Print)____
Participant or Parent/Guardian Signature____
Print Parent/Guardian Name (If Applicable)____________________________________
Relationship to Participant____
Address____
City _______________________________________ State_____ Zip_________________

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PHOTO AND RESEARCH DATA RELEASE

Print Participant's Name____
Print Parent/Guardian Name (If Applicable)_____________________________________
Address ____
City ______________________________________State________ Zip Code _____________

PHOTO RELEASE

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to the **BACK BAY THERAPEUTIC RIDING CLUB, INC.,** permission to take or have taken still and moving photographs and films, including television pictures, of my/our self-daughter-son-ward __ _________________________________(participant's name)and consents and authorizes the **BACK BAY THERAPEUTIC RIDING CLUB, INC.,** to use and reproduce the photographs, films and pictures and to circulate and publicize the same by all means including, but not limited to, newspapers, television media, brochures, pamphlets, instructional material, books and clinical material.

With respect to the foregoing matters, no inducements or promises have been made to me/us to secure my/our signature(s) to this release other than the intention of the **BACK BAY THERAPEUTIC RIDING CLUB, INC.,** and its work.

SIGNED ____ DATE _______

Relationship to Participant____

RESEARCH DATA RELEASE

The undersigned hereby grants permission to use all test results and scores obtained from evaluations, both formal and informal of my/our self-daughter-son-ward_____________________ (Participant's name) while said was in attendance at **BACK BAY THERAPEUTIC RIDING CLUB, INC.** The material will be used for the purpose of research to be conducted by the above named facility's staff and/ or consultants.

With regard to the foregoing statements, no use of the above named participant will be included in published material. No promises have been made to me/us to secure my/our signatures to this release other than the intention of the above named facility to use the test results and scores obtained from evaluations for the purpose of educational work and research.

SIGNED____DATE_______________

Relationship to Participant ____

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POSSIBLE REASONS FOR PATIENT/CLIENT DISCHARGE

Please be advised of the following reasons that may lead to discharge from the therapy program and/or from the BACK BAY THERAPEUTIC RIDING CLUB. The duration of therapy treatment time is variable, however at some point **all clients will be discharged from therapy**. It is determined at the time of discharge from the therapy program options to transfer to sport riding program or the possible discharge from the Back Bay Therapeutic Riding Club entirely.

1. Patient/client has reached all their goals!
2. Patient's/client's potential to maintain head and neck control in sitting presents a safety concern.
3. Inability to follow directions is interfering with progress toward treatment goals.
4. Uncontrolled and inappropriate behavior that constitutes a safety risk to patient/client and/ or staff.
5. Patient/client exceeds weight that can safely be managed by staff, volunteers, and/or therapy horses.
6. Any change in the patient's/client's medical, physical, cognitive, or emotional condition that makes hippotherapy or therapeutic riding inappropriate.
7. Three scheduled sessions are missed without prior canceling, at the discretion of the treating therapist and/or instructor.
8. Non payment of billed funds after 90 days

Signature of Patient/Client or Legal Guardian: _____________________Date:_________

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Dear Physician:

One of your patients is interested in therapeutic horseback riding lessons. Each new student must submit a completed physician assessment form in order to enroll in our program. Your completion of this form will assist our therapists and instructors in designing an individual lesson plan for your patient that is both safe and effective.

Please make special note of any precautions/contraindications that may exist.

Therapeutic riding enhances the quality of life for many children and adults with physical, cognitive or psychological disabilities. Your participation in our program is invited. Please feel free to call or visit if you would like more information.

Sincerely,

Bernadette Olsen
Advanced Therapeutic Riding Instructor/Program Director

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PHYSICIAN ASSESSMENT

PATIENT'S NAME____

PARENTS/GUARDIAN____

ADDRESS____

DATE OF BIRTH__________________HEIGHT____________________WEIGHT_____________

DIAGNOSIS__________________________________DATE OF ONSET______________________

HOSPITALIZATION/SURGERY(Dates & Reasons)__________________________________

____

____

MEDICATIONS____

SHUNTS/IMPLANTS/APPLIANCES____

MOBILITY ASSISTING DEVICES____

IS A SEIZURE DISORDER PRESENT?____

SEIZURE TYPE_______________________________DATE OF LAST SEIZURE______________

PLEASE INDICATE AND COMMENT ON ANY SPECIAL PROBLEM AREAS BELOW:

AREA	YES	NO	COMMENTS
AUDITORY			
VISUAL			
SPEECH			
CARDIAC			
CIRCULATORY			
PULMONARY			
NEUROLOGICAL/SENSATION			
MUSCULAR			
ORTHOPEDIC **(Note Hip Sublux.)**			
BOWEL/BLADDER			
ALLERGIES			
COGNITION			
PSYCHOLOGICAL			
BEHAVIOR			
OTHER			

PLEASE INDICATE ANY SPECIAL PRECAUTIONS/CONTRAINDICATIONS TO THERAPEUTIC HORSEBACK RIDING____

____

FOR PERSONS WITH DOWN SYNDROME – A CERVICAL X-RAY TO EXCLUDE ATLANTOAXIAL INSTABILITY IS MANDATORY:

X-RAY DATE______________________RESULTS__________________________________

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PHYSICIAN RELEASE

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the Back Bay Therapeutic Riding Club will weigh the medical information above against any existing precautions and/or contraindications before accepting this person for therapeutic horseback riding lessons. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. Physical Therapist, Occupational Therapist. Psychologist, etc.) in the implementing of a safe and effective equestrian program.

PHYSICIAN SIGNATURE ______________________________DATE ___________

PHYSICIAN NAME/ADDRESS/PHONE (PLEASE PRINT OR USE STAMP):

____

____

____

STAMP ____