North Carolina Therapeutic Riding Center
4705 Nicks Road, Mebane, NC 27302
919-304-1009 (office) – 919-869-1410 (fax)
www.nctrcriders.org

Dear Prospective NCTRC Participant:

Thank you for your interest in the North Carolina Therapeutic Riding Center (NCTRC). Enclosed, you will find a Participant Consent and Release Form, Participant Application Form with Rider Information Questionnaire and a Physician/Medical Statement form. The first step toward participating in a NCTRC session is to complete and return these forms. The application and rider information forms are for you to complete, and your physician completes the Medical form. The forms can be mailed or faxed to the above address or number. Once we have received **ALL** forms, we will contact you to schedule an evaluation. The cost of the evaluation is $55 dollars. Please send in the payment with your previously mentioned application forms. In the event that we cannot provide you with an evaluation, your payment will be refunded.

During the evaluation, we will ensure that our program is appropriate for you and that there are no contraindications to you or your child's participation. We will discuss our services to determine how we can best meet your needs. We will also conduct a brief evaluation on the horse. Please come to your evaluation dressed to ride (long pants and closed toe shoes). Riding helmets are provided for all riders. Following the evaluation and the determination that we can safely accommodate you, you will be eligible to register for our next riding session.

We strive to provide the safest possible conditions for participants, volunteers, and employees. NCTRC is a Premiere Accredited Center, and we adhere to all precautions and contraindications established by the Professional Association of Therapeutic Horsemanship, International, or PATH International (formerly the North American Riding for the Handicapped Association). The acceptance, and continued participation of a rider, in our program depends on the availability of instructors, volunteers, and suitable horses. NCTRC retains the right to refuse any participant that we cannot safely accommodate. Though we are able to accommodate a wide range of challenges, NCTRC will determine from your forms and your evaluation as to whether things like uncontrolled seizures, weight over our 200 lb limit or spinal instability, to name a few, would render this activity inappropriate for a prospective participant. **If you have any questions as to what may be a contraindication, please do refer to the Health Care Provider letter in this packet or contact us with any questions.**

Participants must inform us of changes in health status. NCTRC requires regular updates of the Medical History Form in addition to updates needed following changes in health status, hospitalization, and surgery.

Thanks again for your interest in our program. We look forward to meeting you!

Sincerely,

Jackie Cole

NCTRC Program Director

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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 service of, or while being on the property of the North Carolina Therapeutic Riding Center (NCTRC), I authorize NCTRC to secure and retain medical treatment and/or transportation if needed. This authorization includes but is not limited to x-ray, surgery, hospitalization and medication. In addition, I authorize NCTRC to release my/my child's/my ward's records to any individual involved in medical treatment and/or necessary transportation.

Participant's Name _____

In case of emergency: 1st contact _____ Phone _____

2nd contact _____ Phone _____

Physician's Name _____ Phone _____

Insurance _____ Policy # _____ Preferred Facility _____

Date _____ Participant Signature _____.
(or signature of parent/guardian if participant is under age 18 yrs.)

Non-Consent Plan: I do not give my consent for emergency medical treatment/aid, in the case of illness or injury while participating in activities with the North Carolina Therapeutic Riding Center. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

Non-Consent Signature _____ Date _____
(or signature of parent/guardian if participant is under 18 yrs.)

Photo Release (Check one)

___ I hereby consent to and authorize the use and reproduction by the North Carolina Therapeutic Riding Center of any and all photographs and any other audiovisual materials taken of me/my child/ my ward for promotional printed material, educational activities or for any other use for the benefit of the program.
___ I do not consent to the above use of photo or videographic materials.

Date _____ Participant Signature _____.
(or signature of parent/guardian if participant is under age 18 yrs.)

LIABILITY RELEASE: Under Chapter 99E of the North Carolina General Statutes, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting exclusively from the inherent risks of equine activities.

Whereas,_____ (Participant's name) would like to participate in the North Carolina Therapeutic Riding Center (NCTRC) equestrian programming conducted at the farm located at 4705 Nicks Rd in Mebane, NC and hereby acknowledges his or her understanding of the inherent risks involved in riding and working around horses, which risks include bodily injury, disability or death from accidents incurred while using, riding, or being proximate to horses; and further acknowledges that both horse, rider and volunteers assisting with therapeutic riding classes can be injured in normal use or in competition and schooling;
Now Therefore, in exchange for the opportunity to participate in therapeutic programming conducted by NCTRC the Undersigned does hereby release and forever discharge NCTRC, the farm owners and their employees, volunteers, heirs, successors, assigns, and personal representatives from any and all actions, causes of action, claims, demands, damages, charges and expenses, including court costs and counsel fees, and against all loss and damages whatever, for upon or by reason of any personal property loss, personal injury, disability or death which may result from any activity or involvement that the Undersigned engage in through NCTRC.

I DO EXPRESSLY CONSENT TO ASSUME ANY RISK, CHANCE OF HARM, PERSONAL OR REAL PROERTY DAMAGE, INJURY, SUFFERING, DISABILITY OR DEATH INVOLVED WITH OR RESULTING FROM MY PARTICIPATION IN PROGRAMS CONDUCTED BY NCTRC.

Date _____ Participant Signature _____.
(or signature of parent/guardian if participant is under age 18 yrs.)

Revised 4/8/14

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PARTICIPANT APPLICATION (THREE PAGES)

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

Participant's Name _____ Date of Birth _____ Age _____

Male __ Female __ Race/Ethnicity (optional) _____ Diagnosis _____

Address _____ CIty_____ State_____ Zip_____

School Name _____

Parent or Guardian Name(s) _____

Rider or Guardian Employer _____

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

Home _____ Name (if not participant) _____

Work _____ Name (if not participant _____

Cell _____ Name (if not participant _____

Email _____ Participant or Caregiver (circle one)

How did you hear about our program? _____

RIDER INFORMATION AND HEALTH HISTORY QUESTIONNAIRE

NCTRC would like to know more about our riders in order to serve them best. For example, what is motivating, what is helpful, what could be safety concerns? Thanks you for completing this questionnaire.

Describe abilities and needs or difficulties in each of the areas below. The words in parentheses are only suggested things to consider.

1. **Communication** (ability to understand, to express wants and needs, to communicate with peers socially)

If there are needs in this area, what strategies are currently being used and which are most beneficial? (picture schedule, signing etc.)

2. Learning Style (attention, following directions, abstract concepts, reading ability)

If there are needs in this area, what approaches are currently most helpful?

3. Physical Function (mobility, balance, strength, coordination, self-care, hand-writing)

If there are needs in this area, what adaptations are used (walking aids, orthoses, etc.)

4. Sensory Systems (vision, hearing, sensory processing, hypersensitivities to touch, textures, sound)

If there are any needs in this area, what coping strategies are most helpful?

5. Personality and Behavior (confident, shy, easy going, anxious, fearful, impulsive, aggressive)

What things are most motivating?

If there are significant needs, what strategies are helping?

6. Medical needs that we should be aware of (breathing concerns, any seizures, allergies, recent surgeries)

Current Medications and Care Plans:

7. What therapy is being received? Who is providing therapy?

8. Goals: What are the most important areas for change?

What would you like to see addressed in therapeutic riding or hippotherapy activities?

Person Completing Questionnaire _____

Relationship to Rider _____

Signature _____Date _____

Revised 4/8/14

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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 Medical History. 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.

Orthopaedic

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
Hydrocphalus/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
Migraine
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 919-304-1009. If directly returning the form to NCTRC, you may either mail or fax it to the following:

NCTRC Program Director
4705 Nicks Road
Mebane, NC 27302
(919) 869-1410 (fax)

Sincerely,

Jackie S. Cole

NCTRC Program Director

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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: Shunt: Yes □ No □ Date of Last Revision _____

Seizures: Yes □ No □ Seizure Type _____ Date of Last Seizure_____ Now Controlled? Yes □ No □

Down Syndrome: Atlanto Dens Interval X-rays, Date _____ Result: (circle) **+** **-**

Any Neurologic Symptoms of Atlanto Axial Instability? _____

Primary Diagnosis/Presenting Concern _____ Date 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			
Orthopaedic-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 the referral of the patient to a licensed/credentialed therapist or health professional, as necessary, for evaluation of abilities/limitations in performing exercises and in the implementation of an effective equine activity program.

Date_____ Name & Title (print) _____ MD DO NP PA

Signature _____ Phone _____

Address _____ City _____ State _____ Zip _____

Revised 4/8/14