Rider/Participant Application Form

PARTICIPANT NAME: ____

Address: ____

DOB: ____________ Age: ____ Height: _____ Weight: ______ (website and policies for guidelines) Gender: M F

Employer/School: ____

PARENT/LEGAL GUARDIAN (if under age 18): ____

Address (if different from above): ____

Phone: (H) _________________________ (C) _________________________ (W) _________________________

EMAIL ADDRESS: ______________________________________ (***Email is our primary form of communication***)

______ I do not have access to email, please contact me via: ____

INDIVIDUAL RESPONSIBLE FOR SCHEDULING AND TRANSPORTATION: ______________________________

Address (if different than above): ____

Phone: _________________ Email: ____

INDIVIDUAL/AGENCY RESPONSIBLE FOR PAYMENT: ____

Address (if different than above): ____

Phone: _________________ Email: ____

IRIS Eligible: Yes No   IRIS Consultant Name: ____

Phone: _________________ Email: ____

REFERRAL SOURCE: ____Phone: ____________________

How did you hear about REINS? ____

Describe your previous riding experience and current level of riding: ______________________________________

____

Describe your horseback riding or other program goals: ____

____

What specific physical, cognitive and /or emotional goals do you have? ___________________________________

____

Is there anything that would be helpful for the staff or volunteers to know about you or your learning style?

____

Do you have a family member/other person who might be interested in volunteering for class or in another capacity?

Name: ______________________________ **Phone:** _________________________ **email:** _____________________

Please attach Recent Photo and indicate T-Shirt Size

Youth *SM___MD___LG___* ***Adult*** *SM___ MD___LG___XL___XXL___*

Weeks wishing to participate:
June 12____ June 19____ June 26____ July 3____ July 10____ July 17____July 24____
July 31____Aug 7____ Aug 14_____

Possible Reasons for Participant Discharge

Please be advised of the following reasons that may lead to discharge from the REINS, Inc. program.

1. Participant displays a condition listed by Professional Association of Therapeutic Horsemanship International (PATH) as a contraindication to therapeutic riding.
2. Participant's potential to maintain head and neck control in a sitting position presents a safety concern.
3. Inability to follow directions is interfering with progress toward treatment goals.
4. Uncontrolled and inappropriate behavior that may constitute a safety risk to participants, volunteers or staff.
5. Participant exceeds weight limit that can safely be managed by staff, volunteers, and/or horses.
6. Any change in the participant's medical, physical, cognitive or emotional condition that makes therapeutic riding inappropriate.
7. Three scheduled sessions are missed without prior cancellation .
8. Nonpayment after first lesson of each session.

____ Date: _____________

Signature of participant, parent or legal guardian

Please note the following important REINS policies:

1. Scheduling is done on a first come first served basis. Please send your completed Participant (Rider) Application Form, in its entirety, and payment by the due date.
2. You will receive a session confirmation prior to the beginning of the session(s) that you have signed up for.
3. All forms and information are kept strictly confidential.
4. To accommodate everyone, lessons must start on time and may not be interrupted if you arrive late.
5. Per the advice of our veterinarian and Professional Association of Therapeutic Horsemanship International's precautions and contraindications, it is necessary for us to limit the weight that our horses carry. All riders must be 220 lbs. or less for balanced independent riders, 200 lbs. if side walker assistance is needed for balance. Therefore, it is mandatory that the height/weight portion of the forms be filled out accurately prior to participation. Participation in our riding program for the above mentioned reasons and others remain at the discretion of the Director(s) of the program and veterinarian.
6. Spectators under the age of 18 must be supervised by parent/guardian while at the REINS facility. Parent/guardian must take full responsibility for any/all incidents arising from lack of direct supervision. Direct supervision is not the responsibility of REINS, Inc. or any of its employees, volunteers, other parents/guardians, riders or visitors.
7. Parents/guardian or other authorized staff must remain at the REINS facility during the full course of their participant's lesson.

My signature below indicates that I have read, understand and will comply with the above listed REINS policies:

____ Date: _________________
Signature of participant, parent or legal guardian

Liability Release

_______________________________ (participant's name) would like to participate in the REINS, Inc. program. I acknowledge the risks and potential for risks of horseback riding and related activities. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Majestic Meadows Dairy LLC and REINS, Inc., its Board of Directors, instructors, therapists, aides, volunteers, facility owners, and/or staff for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in REINS, Inc. activities.

____Date: _________________
Signature of participant, parent or legal guardian

Photo Release

____ **I Do** ____ **I Do Not**

Consent to and authorize 1) REINS, Inc. Therapeutic Riding Program may use my (my child's) photograph or image in its print, online and video publications; 2) release REINS, Inc. Therapeutic Riding Program, its employees and any outside third parties from all liabilities or claims that I might assert in connection with the above-described activities and 3) I waive any right to inspect, approve or receive compensation for any materials or communications, including photographs, videotapes, DVDs, website images or written materials, incorporating photos/images of me (my child).

____Date: _________________
Signature of participant, parent or legal guardian

Permission to Share Information with Lesson Volunteers

____ **I Do** ____ **I Do Not**

Give permission to REINS, Inc. instructors to share information they deem appropriate regarding me/my son/my daughter/my ward and his/her disability/lesson goals/communication style, including any specific needs or precautions, with the lesson volunteers. This release is valid for one year and can be revoked, in writing, at my request.

____Date: _________________
Signature of participant, parent or legal guardian

Authorization for Emergency Medical Treatment

Participant's Name: ___________________________________ DOB: ___________ Phone: __________________

Address: ___________________________________City: ___________________________Zip: ______________

Physician's Name: ____ Phone: ___________________________

Preferred Medical Facility ____

Health Insurance Company: ____________________________________Policy # __________________________

Allergies to medications or foods: ____

Current medications: ____

In the event of an emergency contact:

Name: ____ Relation: __________________

Phone #1:____________________Phone #2:____________________

Name: ____ Relation: __________________

Phone #1:____________________Phone #2:____________________

Name: ____ Relation: __________________

Phone #1:____________________Phone #2:____________________

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services or while being at the REINS facility, I authorize REINS, Inc. to:

1. Secure and retain medical treatment and transportation, if needed.
2. Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment.

Medical Treatment Consent Plan

This authorization includes x-rays, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician in the event of illness or injury while receiving services. This provision will only be invoked if the person(s) above is unable to be reached.

Date: ___________ Consent Signature: ____
Participant, parent or legal guardian (Signed in the presence of center staff)

Medical Treatment Non Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury while receiving services. In the event emergency treatment/aid is required, I wish the following procedure to take place:

____

____

Date: _________ Non Consent Signature: ____
Participant, parent or legal guardian (Signed in the presence of center staff) **Records Access Authorization**

TO WHOM IT MAY CONCERN:

Pursuant to the regulations under HIPAA, this memorandum is authority for you to provide to REINS, Inc. or their authorized representative, all medical records, psychiatric records, hospital records, x-rays, technicians' reports, pharmacy or drugstore records, medical charts, office's notes, physician's reports or other related medical information related to the examination and treatment of _____________________________________ (name of participant).

I, _______________________________ (name of participant, parent or legal guardian), understand that the information used or disclosed may be subject to redisclosure by the person or class of persons or facility receiving it, would then no longer be protected by federal regulations.

I, _______________________________ (name of participant, parent or legal guardian), may revoke this authorization by notifying REINS, Inc. in writing of my desire to revoke it. However, I understand that my action already taken in reliance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

A photocopy of this authorization may be accepted with the same force and effect as an original. This authorization is valid for one year.

Dated: ____________________

Signature of participant, parent or legal guardian: ____

DOB: _____________________

SS# ______________________

State of Wisconsin, County of ____________________________

On this day of _________________, 2017, before me personally came and appeared to me known and known to the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that she/he executed the same.

____

Witness of legal age

<u>Send this form along with the following pages which are to be completed by the participant's physician.</u>

Medical History and Medical Statement

Must be completed by physician

It is very important that we have accurate height and weight for the appropriate assignment of horses. It must be current within three months of June 1, 2017.

Date: ________________

Dear Physician: ________________________________

Your patient, __________________________is interested in participating in supervised equestrian activities,
(Participant's name)
In order to safely provide this service, REINS, Inc. requires that you complete the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindication to therapeutic horseback riding. Therefore, when completing these forms, please note whether the conditions are present and to what degree.

Weight: ________ Height: ________ DOB: __________

Diagnosis: ____Date of Onset: __________

Past/Prospective Surgeries: ____

Medications: ____

Seizure type____

Controlled: Y N Date of last seizure: ________________________

Shunt present: Y N Date of last revision: ________________________

Date of last Hip Radiograph: _______Result (please describe) ____

Special precautions/needs: ____

____

Mobility:
Independent Ambulation Y N Assisted
Ambulation Y N
Wheelchair Y N

Braces/assistive devices: ____

What physical, cognitive and/or emotional goals do you have for this participant? ______________________________

____

Is there any further information that you think REINS, Inc. should know regarding the medical condition of this

individual? ____

Patient's Name: ____Date: _____________________

Please indicate whether these conditions are present and to what degree. Please attach any necessary additional information.

Orthopedic

___ Atlantoaxial instability – include neurologic symptoms

___ Coxa Arthrosis

___ Cranial Defects

___ Heterotopic ossification/Myositis Ossificans

___ Joint subluxation/dislocation

___ Osteoporosis

___ Pathologic fractures

___ Spinal fusion/fixation

___ Spinal instabilities/abnormalities

Neurologic

___ Hydrocephalus/shunt

___ Seizure

___ Spina Bifida

___ Chiari II malformation

___ Tethered cord

___ Hydromyelia

-**Other**

___ Age –under 4 years

___ Indwelling catheters

___ Skin breakdown

___Poor endurance

____ Medications
(ie. Photo Sensitivities)

Medical/Psychological

___ Autism.

____ ADHD

___ Allergies

___ Animal abuse

___ Physical/Sexual/Emotional Abuse

___ Blood Pressure control

___ Dangerous to self or others

___ Exacerbations of medical conditions

___ Fire Settings

___ Heart conditions

___ Hemophilia

Atlantoaxial Instability or focal neurologic disorder clearance
Date: _____________

___Down's Syndrome
(Physician's AAI clearance
required yearly)

Medical/Psychological (Continued)

___Substance abuse

___Thought control disorder

___Varicose veins

___Weight control disorder

___ Medical Instability _

___ Migraines

___ PVD

___Respiratory Compromise

___Recent surgeries

Health History

Diagnosis **Date of Onset:**

Please indicate current or past special needs in the following areas, including surgeries

	YES	NO	Comments
Special Needs			
Allergies			
Auditory/hearing			
Balance			
Cardiac/heart			
Circulatory			
Cognitive/thinking			
Emotional/Psychological			
Immunity			
Integumentary/skin			
Learning Disability			
Muscular			
Neurologic			
Orthopedic/bone/joint			
Pain			
Pulmonary/breathing			
Speech/communication			
Tactile/touch Sensation			
Visual			

After careful review of ___________________________________ (participant's name) medical history and consideration of the risks of equestrian activities, to my knowledge, there is no reason why this person cannot participate in supervised equestrian activities.

Printed Name_____________________________________ Title: _____________________ MD DO NP PA Other

Signature: ____Date: ____

Phone: _____________________________ Email: ____

Address: ____

License/UPIN Number: ____

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equestrian activities, please feel free to contact REINS, Inc. at (920)946-8599.

PLEASE MAIL COMPLETED FORMS TO: REINS, Inc. PO Box 68 Sheboygan Falls, WI 53085-0068