SHADOW HILLS RIDING CLUB

Participant Name_____Date_____

PARTICIPANT/RIDER PACKAGE CHECKLIST

All of the forms listed below are required to be completed, checked, signed and dated as indicated prior to the start of rider participation and annually thereafter.

To be completed by rider, parent or caregiver:

- ☐ 1- Participant Registration Form
- ☐ 2- Contact and Tuition Payment
- ☐ 3- Participant Release
  - ○ Liability Release
  - ○ Confidentiality Agreement
  - ○ Photo and Video Release
  - ○ Mental Health Release
- ☐ 4- Authorization for Emergency Medical Treatment Form
- ☐ 5- Program Eligibility and Discharge
- ☐ 6- Participant/Rider Goal Sheet

Please note that general rider info and medical records need to be updated annually with SHRC to continue as a participant in our program.

To be completed by the rider's physician:

- ☐ 7- Physician Information
- ☐ 8- Participant Health History/Physician Assessment Form
- ☐ 9- Physician Release
- ☐ *10- For Participants with Downs Syndrome - Cervical X-ray results for Atlanto-axial Instability (if applicable)*

For office use only - check off when received

Forms	1	2	3	4	5	6	7	8	9	10	Eval
Check											

SHADOW HILLS RIDING CLUB

Participant Name_____Date_____

1- PARTICIPANT REGISTRATION

DOB _____Age _____ Height _____ Weight_____ Gender_____

Primary Diagnosis_____

Secondary Diagnosis_____

Mobility status (walks unassisted, assistant devices, etc) _____

Communication (verbal, non-verbal signs) _____

Behaviors (impulsive, fearful, frustration tolerance) _____

Medications Taken_____

Seizures (if applicable please describe) _____

Limitations_____

Allergies_____

Skin sensitivity_____

Participant's occupation/ school grade level_____

Affiliate Program if applicable_____

Personal Goals (fill in the areas that apply):

Physical_____

Cognitive_____

Social/Behavioral_____

Life skills_____

Other_____

Availability for the Shadow Hills Program (Check all available times and days)		Tuesday	Thursday	Saturday
	Morning			
	Afternoon			

First date available to start (will officially be determined at assessment):_____

SHADOW HILLS RIDING CLUB

Participant Name_____Date_____

2- CLIENT CONTACT INFORMATION

Street Address _____

City_____State_____Zip_____

Home Phone _____ Cell _____

Email Address_____

Parent/Guardian Information:

Parent/Guardian 1_____Relation_____

Phone_____Email_____

Occupation_____Work Phone_____

Parent/Guardian 2_____Relation_____

Phone_____Email_____

Occupation_____Work Phone_____

How were you referred to Shadow Hills Riding Club?_____

PROGRAM TUITION PAYMENT DETAILS

Please tell us how you will be paying:

- ☐ Check (please make payable to Shadow Hills Riding Club)
- ☐ Paypal/Online
- ☐ Credit Card (add info below)
- ☐ Other:_____

I _____ authorize Shadow Hills Riding Club to charge $_____ to my credit card.

Name on Card_____Billing zip code_____

Card Number_____ Exp._____CVV_____

Cardholder signature_____Date_____

I understand and agree that all paperwork must be up to date and that all tuition is to be paid prior to the start of each session.

Signature of Rider or Legal Guardian_____ Date_____

SHADOW HILLS RIDING CLUB

Participant Name_____Date_____

3- PARTICIPANT LIABILITY RELEASE, CONFIDENTIALITY AGREEMENT, PHOTO & VIDEO RELEASE, AND MENTAL HEALTH SERVICES RELEASE

LIABILITY RELEASE

Name of Participant/Parent/Guardian/Conservator_____ I acknowledge the risks and potential risks for horseback riding and activities in and around a facility where horses are kept and farm machinery operated. However, I feel that the possible benefits to me/my son/my daughter/my ward are greater than the risk assumed. Intending legally to bind myself, my heirs, and assigns, executors or administrators, I hereby waive and release forever all claims for loss or damages of any kind against Shadow Hills Equestrian Center LLC, Shadow Hills Riding Club Inc., Saddles for Soldiers Inc., its Board of Directors, Instructors, Therapists, aids, Volunteers and employees for any and all injuries and losses that I/my son/my daughter/my ward may sustain while participating in the programs associated with Shadow Hills Riding Club and/or Saddles for Soldiers. This release includes without limitation the risk of negligent instruction and supervision. I engage in activities at the Shadow Hills Equestrian Center voluntarily with knowledge of the risks and I assume all risks of injury, death, and property damage that may result. I agree to bear any loss myself. I acknowledge that Shadow Hills Equestrian Center, Shadow Hills Riding Club, Saddles for Soldiers and the property owners are materially relying on this waiver and assumption of risk in allowing me/my son/my daughter/my ward to participate in the Shadow Hills Riding Club activities on the property of Shadow Hills Equestrian Center.

Date_____ Signature_____
(Participant, Parent or Caregiver)

CONFIDENTIALITY AGREEMENT

I understand that all the information (written and verbal) about participants at this Professional Association of Therapeutic Horsemanship (PATH, International center) is confidential and not to be shared with anyone without expressed written consent of the participant and their parent/guardian in the case of a minor.

Date_____ Signature_____
(Participant, Parent or Caregiver)

PHOTO AND VIDEO RELEASE

- ☐ I consent to and authorize
- ☐ I do not consent to nor do I authorize

The use and reproduction by Shadow Hills Riding Club of any other audio/visual materials taken of me/my son/my daughter/my ward for distribution to the public for promotional printed materials, educational activities or for any other use for the benefit of the program.

Date_____ Signature_____
(Participant, Parent or Caregiver)

MENTAL HEALTH SERVICES RELEASE

I understand that activities and services offered at Shadow Hills Riding club may include mental health counseling. I have discussed this with my/my child's/my ward's doctor. I understand that no liability can be accepted by any of the organizations concerned with this mental health counseling, including Shadow Hills Riding Club, Saddles for Soldiers, associated counselors and personnel.

Date_____ Signature_____
(Participant, Parent or Caregiver)

SHADOW HILLS RIDING CLUB

Participant Name_____Date_____

4- AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Physician's Name_____Phone_____

Preferred Medical Facility_____

Health Insurance Company_____ Policy #_____

Allergies to Medications_____

Current Medications_____

In the Event of an Emergency Contact:

Name_____ Relation_____ Phone_____

Name_____ Relation_____ Phone_____

Please check either the consent or non-consent and sign and date underneath your choice.

☐ **Consent for Emergency Medical Treatment:**

In the event of an 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 Shadow Hills Riding Club 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-rays surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date_____ Consent Signature_____
(Client, Parent or Legal Guardian)

☐ **Non-Consent for Emergency Medical Treatment:**

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 agency. Parent or legal guardian will remain on site at all times during equine assisted activity

In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

Date_____ Non-Consent Signature_____
(Client, Parent or Legal Guardian)

SHADOW HILLS RIDING CLUB

Participant Name_____Date_____

5- PROGRAM ELIGIBILITY AND DISCHARGE

PARTICIPANT ELIGIBILITY REQUIREMENTS

All clients must meet the following guidelines in order to begin as a participant in the SHRC program:

1. Client must fully complete New Participant/Rider packet
    a. No child can be accepted for the Shadow Hills Riding Club program until all forms have been completed by the parent/guardian.
    b. If the client is of legal age and mentally competent, they may complete the forms without the parent's or guardian's signature."
2. Client must complete the initial evaluation
3. Client does not have any contraindications for either mounted or groundwork activities
4. Client cannot exceed a weight that can safely be managed by staff, volunteers, and/or horses (if engaging in mounted activities)

POSSIBLE REASONS FOR PARTICIPANT DISCHARGE

Please be advised of the following reasons that may lead to discharge from the riding program.

1. The participant has reached all of their goals and is ready to graduate.
2. The participant's potential to maintain head and neck control while riding presents a safety concern.
3. Inability to follow directions is interfering with progress toward goals.
4. Uncontrolled and/or inappropriate behavior that constitutes a safety risk to client, staff and/or horse.
5. The participant exceeds weight 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 appointments are missed without prior cancellation.
8. Non-payment of fees as originally agreed.

I understand and agree with the eligibility requirements and possible reasons for participant discharge.

Date_____Signature_____
(Client, Parent or Legal Guardian)

SHADOW HILLS RIDING CLUB

Participant Name_____Date_____

6- PARTICIPANT/RIDER GOALS

Help us help you get the most out of your classes by filling out the following goal setting sheet. Please return this page to your instructor at the next class. Thank you.

Lesson day_____ Time_____

All goals are reflective of the next term. The categories are meant as a guideline and may not apply to all students.

Please enter any applicable goals below:	
Riding	
Physical	
Cognitive	
Social	

SHADOW HILLS RIDING CLUB

Participant Name_____Date_____

FORMS 7-9 SHOULD BE COMPLETED BY THE RIDER'S/PARTICIPANT'S PHYSICIAN

7- PHYSICIAN INFORMATION

Information for Physician

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Please complete the Shadow Hills Medical Release and Health History Assessment forms.

Note if any of the following conditions are present, and to what degree:

Orthopedic		
Condition	**Y/N**	**To what degree if "Y"**
Spinal Fusion		
Spinal Instabilities/ Abnormalities		
Atlantoaxial Instabilities		
Scoliosis		
Kyphosis		
Lordosis		
Hip Subluxation and Dislocation		
Osteoporosis		
Pathological Fractures		
Coxas Arthrosis		
Heterotopic Ossification		
Cranial Deficits		
Spinal Orthoses		
Internal Spinal Stabilization Devices		
Secondary Concerns		
Behavior Problems		
Age under 2yrs		
Age 2-4yrs		
Indwelling Catheter		
Acute Exacerbation of Chronic Disorder		

Medical/Surgical		
Condition	**Y/N**	**To what degree if "Y"**
Allergies		
Cancer		
Poor Endurance		
Recent Surgery		
Diabetes		
Peripheral Vascular Disease		
Varicose Veins		
Hemophilia		
Hypertension		
Serious Heart Condition		
Stroke (Cerebrovascular Accident)		
Neurologic		
Hydrocephalus/ shunt		
Spina Bifida		
Tethered Cord		
Chiari II Malformation		
Hydromyelia		
Paralysis due to Spinal Cord Injury		
Seizure Disorders		

SHADOW HILLS RIDING CLUB

Participant Name_____Date_____

8- RIDER HEALTH HISTORY/PHYSICIAN ASSESSMENT

Diagnosis _____ Date of Onset_____

Past/Prospective Surgeries: _____

Medications_____

Seizures: ☐☐ Type _____ Controlled? ☐☐ Date of Last Seizure _____

Shunts/Implants/Appliances _____

Hospitalizations/Surgery_____

Mobility: Independent Ambulation ☐☐ Assisted Ambulation ☐☐ Wheelchair ☐☐

Neurologic Symptoms of Atlantoaxial Instability_____

Please indicate and comment on any Special Problem Areas Below			
Area	**Yes**	**No**	**Comments**
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological/Sensation			
Bowel/Bladder			
Muscular			
Orthopedic			
Allergies			
Behavior			
Cognition			
Emotional/Psychological			
Other			

SHADOW HILLS RIDING CLUB

Participant Name_____Date_____

9- PHYSICIAN RELEASE

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However I understand that Shadow Hills Riding Club will weigh the medical information contained in the physician release form against existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/ credentialed health professional) e.g. PT, OT, Therapist, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician's Signature:_____ Date:_____

Physician's name, address and telephone number. (please print, type or stamp):

Name:_____

Address:_____

Phone:_____

10- FOR PARTICIPANTS WITH DOWN SYNDROME ONLY MUST HAVE THE FOLLOWING: ATLANTOAXIAL INTERVAL X-RAY

To be filled out, dated and signed by the Riders Physician and returned to the Program Director for Shadow Hills Riding Club prior to any participation in the program

Result_____

Date_____ Physician Signature_____

Please return to Program Director, Johnny Higginson:

Shadow Hills Riding Club
10263 La Canada Way
Shadow Hills, CA. 91040

shadowhillsridingclub.org
info@shadowhillsridingclub.org