

**DISCOVERY RIDERS, INC.**  
**P.O. Box 217**  
**Bellefontaine, Ohio 43311**  
**937-935-6545**

Year: \_\_\_\_\_  
 Session: \_\_\_\_\_

## Participant's Application and Health History

(Must be returned at least 2 weeks prior to the first class)

### GENERAL INFORMATION

Participant: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ M F

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternative #: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_ Email: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Phone: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Contact Numbers: \_\_\_\_\_

How did you hear about the program? \_\_\_\_\_

What days would you prefer for class? (circle) Sun Mon Tues Wed Thur Sat Sun - 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup> choices

### HEALTH HISTORY

Please indicate current or past problems in the following areas: DIAGNOSIS \_\_\_\_\_

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Neurological			
Behavioral/Emotional			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognitive			
Allergies			

(over)

What medications are you currently taking, frequency, administration times including over-the-counter medications? \_\_\_\_\_

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Is there a history of seizures? \_\_\_\_\_ If so, type \_\_\_\_\_ Last seizure \_\_\_\_\_

Warning signs \_\_\_\_\_

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

**FUNCTION** (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

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**SOCIAL** (i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc)

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**GOALS** (i.e. Why are you applying for participation? What would you like to accomplish?)

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**PHOTO RELEASE**

- I  DO
- I  DO NOT

Consent to and authorize the use and reproduction by \_\_\_\_\_ Discovery Riders, Inc.\_\_\_\_\_ of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Client, Parent or Legal Guardian

**DISCOVERY RIDERS, INC.**  
**P.O. Box 217**  
**Bellefontaine, Ohio 43311**  
**937-935-6545**

**AUTHORIZATION for EMERGENCY MEDICAL TREATMENT FORM**

Participant

Staff

Volunteer

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Current medications: \_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

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 Discovery Riders, 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.

**Consent Plan**

The 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(s) above is unable to be reached.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_

Client, Parent or Legal Guardian

**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 agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_

Client, Parent or Legal Guardian

**DISCOVERY RIDERS, INC.**

**P.O. Box 217**

**Bellefontaine, Ohio 43311**

**937-935-6545**

Date: \_\_\_\_\_

Dear Physician:

Your patient, \_\_\_\_\_ (participant's name) is interested:

- \_\_\_\_\_ In supervised equestrian activities
- \_\_\_\_\_ In therapeutic horseback riding lessons
- \_\_\_\_\_ In hippotherapy with a licensed Physical, Occupational, or Speech Therapist

In order to safely provide this service, we request that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. 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

**OTHER**

- Indwelling Catheters
- Medications – i.e. photosensitivity
- Skin Breakdown

**MEDICAL/PSYCHOLOGICAL**

- Allergies
- Animal Abuse
- Physical/Sexual/Emotional Abuse
- Blood Pressure Control
- Dangerous to self or others
- Exacerbations of medial conditions
- Fears
- Heart Conditions
- Hemophilia
- Medical instability
- Migraines
- PVD
- Respiratory Compromise
- Recent Surgeries
- Substance Abuse
- Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact us.

Sincerely,

Linda Hauck, Executive Director  
937-935-7633

(over)

**DISCOVERY RIDERS, INC.**  
**Participant's Medical History & Physician's Statement**

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_

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: \_\_\_\_\_

Gastric Tube Y N Ileostomy Y N Colostomy Y N

Special Precautions/Needs: \_\_\_\_\_

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

Braces/Assistive Devices: \_\_\_\_\_

*For those with Down Syndrome:* AtlantoDens Interval X-rays, date: \_\_\_\_\_ Result: + -

Neurologic Symptoms of Atlanto Axial Instability: \_\_\_\_\_

**Please indicate current or past difficulties in the following systems/areas, including surgeries:**

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Cognitive			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapists and instructors at Discovery Riders, Inc. will weigh the medical information above against the 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, Speech, Psychologist, RN) in the implementations of an effective equestrian program.

Physician's Printed Name: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_

**PERMISSION TO PARTICIPATE IN DISCOVERY RIDERS  
THERAPEUTIC RIDING PROGRAM, DISCLOSURE,  
RELEASE OF CLAIMS, CONSENT TO EMERGENCY MEDICAL TREATMENT  
AND INDEMNIFICATION**

I, \_\_\_\_\_ ("Participant"), have chosen to participate in the Discovery Riders Therapeutic Riding Program ("Program") and its related horse activities. I \_\_\_\_\_ (parent or guardian) have chosen to allow Participant to participate in Program.

I am aware that:

- A. Horses have a tendency to behave in ways, which may result in injury, death, or loss to riders, or other persons in the immediate vicinity;
- B. Horses may react in an unpredictable way to sounds, sudden movement, unfamiliar objects, persons, or other animals;
- C. Riding a horse may give rise to a risk of injury from hazards arising from the surface or subsurface of the ground in which these riding activities occur;
- D. While in the vicinity of a horse or while riding a horse, I may be involved in a collision with another horse, another animal, a person, or an object;
- E. Other participants in the program may fail to maintain control over a horse or fail to act within their abilities, thus causing harm to me or other participants; and
- F. Other participants in the program may act in a negligent manner, which could result in harm to me.

As parent or guardian I have discussed with participant the need to behave in a safe manner. I will make sure that Participant wears appropriate clothing and footwear during horse activities and other program activities.

In consideration for the opportunity to participate in Program activities and the use of services and facilities made available through these Program activities, I do release and forever discharge for myself and my heirs, executors, administrators, and assigns, and for Participant and Participant's heirs, executors, administrators and assigns, the leaders, agents, employees, volunteers, directors, officers, administrators, faculty and staff, of Discovery Riders, from all claims, demands, and causes of action for personal injury or any other damage which may arise out of or be in any way related to Participant's participation in Program.

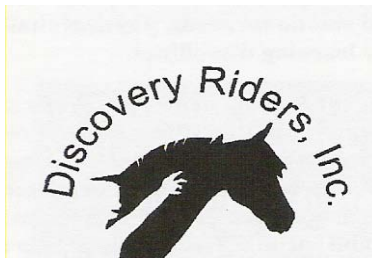
I grant Participant permission to participate in Program and its related horse activities despite the possible risks. I recognize that by participating in these activities, as with any physical activity, participant may risk personal injury. I hereby attest and verify that I have been advised of the potential risks, that I have full knowledge of the risks involved in these activities, and that I assume any expense that may be incurred in the event of an accident, illness, or other incapacity, regardless of whether I have authorized such expenses. As a parent/guardian, I assume the same risk for myself, and other family members and friends present at these Program activities.

In the event of emergency or injury to Participant requiring immediate medical attention for Participant, I hereby consent to emergency medical treatment, including transportation to medical providers, for Participant.

I agree to indemnify and hold harmless Discovery Riders for any claims, damages, or causes of action arising from Participant's conduct and/or participation in Program.

Signed \_\_\_\_\_ Dated \_\_\_\_\_ Signed \_\_\_\_\_ Dated \_\_\_\_\_  
(parent or guardian) (Participant)

**This form needs to be signed and on file for each Participant in any Program activity.**



## FINANCIAL AGREEMENT

Each Therapeutic Riding Session is 6 weeks long, one hour per week. The cost is \$240 for each 6 week session payable the first class of each session, unless other arrangements are made.

Please indicate any funding source that is available to the class participant:

\_\_\_\_ county – name of agency \_\_\_\_\_

\_\_\_\_ state – name of agency \_\_\_\_\_

\_\_\_\_ private scholarship – name of donor \_\_\_\_\_

\_\_\_\_ grant through school \_\_\_\_\_

\_\_\_\_ other \_\_\_\_\_

There is a limited amount of scholarship and United Way money available through Discovery Riders Inc. Please indicate if you are interested in applying for these funds.

\_\_\_\_ yes      \_\_\_\_ no

Families of the class participants are responsible for session costs. The costs of the Therapeutic Riding classes are not reimbursable by insurance companies.

Please indicate where you would like the session invoice to be sent and to whose attention:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Participant Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Relationship \_\_\_\_\_

**Discovery Riders, Inc.**  
Therapeutic Riding  
APPLICATION FOR FINANCIAL ASSISTANCE

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Fill out the following information and return to the Executive Director of Discovery Riders, Inc. Discovery Riders will grant financial aid to the extent that funds are available. Discovery Riders reserves the right to refuse assistance to any applicant. All records are confidential. Please type or print the information.

Date of Application: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Home/Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Pace of Employment: \_\_\_\_\_ How long employed: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Spouse/Child(ren)	Age	School/Employer	Birth Date
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Are you a single parent household? \_\_\_ Yes \_\_\_ No

Your present income level is: \_\_\_ Under \$8,000

\_\_\_ \$8,001 to \$12,000

\_\_\_ \$12,001 to \$15,000

\_\_\_ \$15,001 to \$18,000

\_\_\_ \$18,001 to \$20,000

\_\_\_ \$20,001 to \$25,000

\_\_\_ \$ Over \$25,000

(OVER)

Please itemize your monthly income and expense items

INCOME

EXPENSE

Wages, salaries and tips	\$ _____	Rent/Mortgage	\$ _____
Unemployment Compensation	\$ _____	Utilities	\$ _____
Social Security Compensation	\$ _____	Food	\$ _____
Child Support	\$ _____	Clothing	\$ _____
Aid to Dependent Children	\$ _____	Phone	\$ _____
Food Stamps	\$ _____	Car/Insurance	\$ _____
401K Retirement Funds	\$ _____	Alimony	\$ _____
Alimony	\$ _____	Child Support	\$ _____
Other	\$ _____	Medical	\$ _____
		Other	\$ _____

Total Income \$ \_\_\_\_\_ Total Expense \$ \_\_\_\_\_

Note:

How much do you feel you can afford per 6 week session? \_\_\_\_\_