Trinity Equestrian Center
Healing with Horses

S5300 State Road 37
Eau Claire, WI 54701
(715) 835-4530
trinity-ec.com

Rider Medical History & Physician Release

Patient's (Rider's) Name_____

Person authorizing release of information (print name if different from rider) _____

_____

Name Address Phone

Date_____Signature_____

Primary Diagnosis_____Date of Onset_____

Secondary Diagnosis_____Date of Onset_____

Date of Birth_____Height_____Weight_____

Past/Prospective Surgeries_____

Shunt Present: Yes No If Yes, date of last revision_____

Seizures: Yes No Controlled: Yes No Type_____Date of last seizure_____

Medications_____

For_____

Known Allergies_____

Ambulation (circle): Independent Assisted Wheelchair

Incontinence: Yes No Tetanus Shot: Yes No Date_____

Please indicate any special precautions_____

_____

Physician Signature Required - See reverse side

Please provide information about any conditions or surgeries/issues in the following areas.

Is patient challenged in…			**If yes, please comment (client/guardian may add information)**
Auditory	no	yes	_____
Visual	no	yes	_____
Speech	no	yes	_____
Cardiac	no	yes	_____
Circulatory	no	yes	_____
Pulmonary	no	yes	_____
Neurological	no	yes	_____
Muscular	no	yes	_____
Orthopedic	no	yes	_____
Learning Disability, Emotional/Behavioral Disorder			
	No	yes	_____

☐ **Yes, in my opinion this patient can participate in the Trinity Equestrian Center Therapeutic Riding Program, under appropriate supervision.**

☐ **No, in my opinion this patient should not participate in the Trinity Equestrian Center Therapeutic Riding Program.**

General Comments_____

Physician's Signature_____**Date**_____

Physician's Name (please print)_____

Mailing Address_____

Phone_____ **Thank you!**

PLEASE NOTE: FOR INDIVIDUALS WITH DOWN SYNDROME ONLY

Because of the nature of the horseback riding activity, no individual diagnosed with Down Syndrome can be accepted for riding instruction without the proof of a negative diagnostic X-ray for Atlantoaxial Dislocation Condition.

Physician's Acknowledgement:

I have X-rayed this patient for Atlantoaxial Dislocation Condition and the results are negative. In addition, this patient does not display signs or symptoms of ADC and may participate in the Trinity Equestrian Center Therapeutic Riding Program.

Date of Last X-ray_____

Physician's Signature_____Date_____

Thank you for your cooperation!
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Client Release Form

Client_____Home Phone_____

Address_____City_____Zip_____

E-mail_____Height_____Weight_____

Date of Birth_____Age_____School presently attending_____

Parents or Guardian_____

Address_____City_____Zip_____

Parent or other contact person home & work phone_____

Liability Release (REQUIRED)

In return for being allowed to use Trinity Equestrian Center 's therapeutic riding program, including its facilities, horses and equipment, where applicable for horseback riding and other horse related activities, I/ my son/my daughter/my ward_____ (Client's Name) agree to abide by all rules and regulations of Trinity Equestrian Center now in effect or later adopted. In addition, I hereby agree to assume all responsibility and risk for me and from my son's/my daughter's/my ward's participation in activities at Trinity Equestrian Center. I further agree to hold Trinity Equestrian Center, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees free and harmless from all damages or liability for any injury to person or property arising as a result of the use of facilities, horses and/or equipment owned by or leased to Trinity Equestrian Center, including any injury caused by their negligence.

I am aware of the significant risks of injury that horseback riding and horse-related activities may cause to myself/my son/my daughter/my ward, however I feel that the possible benefits to myself/my son/my daughter/my ward are greater than and out weigh the risk assumed. By signing this agreement, I am assuming all risk and do hereby understand that horses are animals, not subject to any guarantee of reliability. Therefore, I agree to release, indemnify and hold harmless Trinity Equestrian Center, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees from all liability they may incur.

In accordance with the Wisconsin Law relating to the limitation of civil liability regarding equine activities: "NOTICE: A person who is engaged for compensation in the rental of equines or equine equipment or tack or in the instruction of a person in the riding or driving of an equine or in the being a passenger upon an equine is not liable for the injury or death of a person involved in the equine activities resulting from the inherent risks of equine activities, as defined in section 895.481(1)(e) of the Wisconsin Statutes."

Date_____Signature_____
Client, Parent or Guardian

Photo Released (we appreciate your consideration of this!)

☐ I do ☐ I do not

Consent to and authorize the use and reproduction by Trinity Equestrian Center of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional materials, educational activities, exhibitions or for any other use for the benefit of the program.

Exceptions_____

Date_____Signature_____
Client, Parent or Guardian

Authorization for Emergency Medical Treatment
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 Trinity Equestrian Center to:

1. Secure and retain medical treatment and transportation if needed.
2. Released 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 below is unable to be reached.

In the event, I _____can not be reached, please

Contact_____Phone_____

Contact_____Phone_____

Physician's Name_____

Preferred Medical Facility_____

Health Insurance Company_____Policy #_____

Date_____Consent Signature_____
Client, Parent or Guardian

Print Name_____Phone_____

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_____Non-Consent Signature_____
Client, Parent or Guardian

Print Name_____Phone_____

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Volunteer Information Form

Name_____

Address_____City_____Zip_____

Home Phone_____Work Phone_____Cell, Pager, Other_____

Which phone number is the best to reach you?_____Date of Birth_____

E-mail_____

In Case of Emergency (MANDATORY)

Please contact: Name_____Relationship_____

Home Phone_____Work Phone_____Cell, Pager, Other_____

Address_____City_____Zip_____

Physician_____Phone_____

Hospital/HMO and Location_____

☐ **I give my consent to Trinity Equestrian Center to secure medical transportation and treatment, including x-ray, surgery, hospitalization and medication**

☐ **I do not give my consent for emergency medical treatment/aid in the case of illness or injury 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_____Signature_____

Date_____Signature_____

Parent signature for volunteers under the age of 18

Volunteer Liability Release (MANDATORY)

In accordance with the Wisconsin Law relating to the limitation of civil liability regarding equine activities: "NOTICE: A person who is engaged for compensation in the rental of equines or equine equipment or tack or in the instruction of a person in the riding or driving of an equine or in the being a passenger upon an equine is not liable for the injury or death of a person involved in the equine activities resulting from the inherent risks of equine activities, as defined in section 895.481(1)(e) of the Wisconsin Statutes." As a volunteer at Trinity Equestrian Center, I acknowledge the risks and potential for risks of a horseback riding program. However, I feel that the possible benefits to myself and the client I work with 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 Trinity Equestrian Center, its board of directors, instructors, therapists, volunteers, and/or employees for any and all injuries and/or losses I may sustain while participating in Trinity Equestrian Center programs.

Date_____Signature_____

Date_____Signature_____

Parent signature for volunteers under the age of 18

Photo Release (MANDATORY) ☐ I do ☐ I do not

Consent to and authorize the use and reproduction by Trinity Equestrian Center 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.

Date_____Signature_____

Date_____Signature_____

Parent signature for volunteers under the age of 18

Additional Information

Program Volunteer

☐ Therapeutic Riding
- Lead Horse/Sidewalker
- Professional Therapist
- NARHA Certified Instructor

☐ Ranch Care
- Child Care Assistant
- Horse-day Helper

☐ Day Camp Assistant

Facility/Barn

☐ Facility Maintenance
☐ Barn Chores
☐ Site Workdays
☐ Lawn Care / Gardening

Administration

☐ Fund Raising
☐ Volunteer Recruitment
☐ Photography / Video
☐ Grant Writing
☐ Community Connections
☐ Supply Acquisition

How did you learn about Trinity Equestrian Center?_____

State law allows agencies to do background screening on volunteers working directly with children. Do you authorize us to do so? ☐ Yes ☐ No WI Drivers License #_____

Can you walk for 60 minutes and jog short distances? ☐ Yes ☐ No

Do you have any medical conditions we should know about? If so, please describe_____
_____

Are you able to provide transportation assistance to other volunteers living near you? ☐ Yes ☐ No

Please indicate the days of the week and time of day you are able to volunteer:

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
MORNING						
AFTERNOON						
EVENING						

Your Employer:_____

Address_____Products/Services_____

Please describe if you have experience working with individuals who have special needs_____
_____
_____

Do you have a friend who would be interested in receiving volunteer information from Trinity Equestrian Center?

Name_____ Phone Number_____

FOR OFFICE USE ONLY:

VOLUNTEER CALLED Date_____ ADDED TO DATABASE Date_____
VOLUNTEER TRAINING Date_____ REFRESHER TRAINING Date_____

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Instructor's Evaluation

Student (Rider's) Name_____Birthdate_____

Person authorizing information (print name if different from rider)_____

Address_____City_____Zip_____

Date_____Signature_____

Trinity Equestrian Center offers a therapeutic riding program designed to benefit children and adults physically, emotionally, mentally and socially. Specialized safety equipment, extensively trained horses and volunteers, and NARHA (North American Riding for the Handicapped Assoc) certified instructors are utilized. Specific goals are developed for each rider. To maximize the personal benefit from the program, each student is asked to furnish the following information. IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE CONTACT TRINITY EQUESTRIAN CENTER'S PROGRAM DIRECTOR AT (715) 835-4530.

TASK	GOAL / PLAN
Physical skills	
Emotional/mental skills	
Social skills	
Other:	

TASK	GOAL / PLAN
Understanding consequences of personal actions	
Ability to follow directions	
Listening Skills	
Verbalization skills	
Attention span	
Other comments	

****

Signature of Educator_____Date_____

Name_____Employer/School_____

Address_____City_____Zip_____

May we contact you for more information about this evaluation? Phone_____

Would you like more information about Trinity Equestrian Center's therapeutic riding? ☐ Yes ☐ No

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Physical, Speech or Occupational Therapy Evaluation

Patient's (Rider's) Name_____Birthdate_____

Person authorizing information (print name if different from rider)_____

Address_____City_____Zip_____

Date_____Signature_____

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Evaluation date_____

Diagnosis_____

Description_____

Surgeries performed (with dates)_____

_____

_____

Other pertinent medical history_____

Muscle strength: gross_____

Specific weakness_____

Joint ROM: gross_____

Specific weakness_____

Muscle tone_____

Balance: sitting_____standing_____

Coordination: gross motor_____fine motor_____

Reflex activity: developmental_____

Pain: Character_____Location_____

Caused by_____Relieved by_____

Sensory impairments_____

Perceptual problems_____

Communication difficulties_____

Skin condition_____

Functional abilities: mobility_____

Transfers_____

ADL skills_____

Problem list Goals/plan

1.

2.

3.

4.

Additional comments_____

Signature_____R.P.T./O.T.R. Date_____

Name_____Employer/school/clinic_____

Address_____City_____Zip_____

May we contact you for more information about this evaluation? Phone_____

Would you like more information about Trinity Equestrian Center's therapeutic riding? ☐ Yes ☐ No

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Registration - 2009

Rider's Name_____Birthdate_____

Person registering rider (if not rider)_____Relation to rider_____

What phone is best to reach you at in the vent of lesson cancellation?_____

What address is best to send confirmation postcard(s)?_____

Please indicate which session(s) and programs you are registering for:

* MORNING SESSION (Wednesdays @ 10:00 AM - 1 hour sessions)
  _____Therapeutic Riding - 5 Weeks - $150.00
  _____Hippotherapy - ___Weeks - $_____

  REGISTRATION DEADLINE: 10 days prior to session start date
  SESSION START DATES: 01/28; 03/18; 05/06; 06/24; 08/12; 09/30; 11/18

* AFTERNOON SESSION (Mondays @ 4:00 PM - 1 hour sessions)
  _____Therapeutic Riding - 5 Weeks - $150.00
  _____Hippotherapy - ___Weeks - $_____

  REGISTRATION DEADLINE: 10 days prior to session start date
  SESSION START DATES: 01/26; 03/16; 05/04; 06/22; 08/10; 09/28; 11/16

* EVENING SESSION (Mondays @ 5:15 PM - 1 hour sessions)
  _____Therapeutic Riding - 5 Weeks - $150.00
  _____Hippotherapy - ___Weeks - $_____

  REGISTRATION DEADLINE: 10 days prior to session start date
  SESSION START DATES: 01/26; 03/16; 05/04; 06/22; 08/10; 09/28; 11/16

CHECKLIST (deposit, full payment or scholarship request must accompany this application)

_____2008 Trinity Equestrian Center Registration	_____$100 Deposit
_____Trinity Emergency Information & Release Form	_____Full amount enclosed
_____Trinity Medical History & Physician Release Form	_____Scholarship Application Available on website

Trinity Equestrian Center's lesson policies:

- Deposit of $100, full payment or scholarship application must accompany registration for all sessions. Deposit will be refunded if rider is unable to participate in appropriate class and activity, and Trinity Equestrian Center is notified of conflict prior to start of session.
- Credit of $30 (therapeutic riding) will be applied to rider's account when Trinity Equestrian Center staff cancels a lesson or session. Credits must be used by end of following calendar year. Credits carried from 2007 and earlier must be used by end of 2008. Credits may be applied to equine assisted activities at Trinity Equestrian Center only.
- Riders arriving more than 10 minutes late for lessons will not be able to join the class. Fees will not be refunded.
- Refunds will be given if a rider withdraws for the entire session due to medical necessity with written notification from rider's medical provider. No refunds will be offered for vacations, temporary illness or unanticipated circumstances.
- No non–Trinity dogs are allowed on Trinity Equestrian Center grounds.
- Riders with inappropriate shoes (including crocs, sandals, open-toed or open-heeled) will not be able to participate. Fees will not be refunded.

I have read, understand and agree to Trinity Equestrian Center's lesson policies.

Signed_____Date_____

For new and returning riders:

GOALS (Why are you applying for participation? What would you like to accomplish?)

_____

_____

_____

_____

_____

For new riders only:

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

PHYSICAL (Mobility skills such as transfers, walking, wheelchair use, etc.)

_____

_____

PSYCHO/SOCIAL (work/school, leisure interests, companion animals, fears/concerns)

_____

_____

OTHER INFORMATION YOU WOULD LIKE TO SHARE

_____

_____

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Case Worker and Parent Contact Info

For: Client Name_____

Parent's Name_____

Telephone_____E-mail_____

Address_____City_____Zip_____

Caseworker's Name_____

Office Telephone_____E-mail_____

Address_____City_____Zip_____

County_____

Length of Involvement w/Client_____

Goals for Client from Therapeutic Riding Program:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____