Front Range Exceptional Equestrians
PO Box 272452, Ft.Collins, CO 80527-2452
www.frontrangeexceptionalequestrians.org
(970) 443-5124 Office

FREE
Freedom Through Horsemanship

PARTICIPANT APPLICATION & HEALTH HISTORY

_____ _____ _____ _____ _____
Participants Name DOB Height Weight Today's Date

Whom should we contact for scheduling classes? _____
Contact Name

_____ _____
Contact Mailing Address—Street, City, State, Zip+4 Contact Phone

Parent/Guardian Address and Phone (if minor)_____
_____

E-Mail address _____

If applicable -Caregiver name, address, phone, email _____

_____

_____ _____
School or Group Home placement Physician Name/Phone

Please list type of therapy the participant is currently receiving with Therapist Name/Phone

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How did you hear about our program?_____

Are you a returning rider that has participated in our program previously? YES NO

Diagnosis_____ Current Medications: _____

To help us place the participant in an appropriate class, and work effectively with him/her, please check any of the following that describes the participant:

Communication Ability: ____Uses language normally ____Uses Sign Language/finger spelling
____Understands spoken language ____Uses nonverbal communication ___Hearing Impaired
____Client's speech is difficult to understand _____Responds slowly to verbal communication
____Client's speech is usually understood ____Does not respond to verbal communication
Communication aids used by participant are:_____

Physical Skills: ____Sits independently ____Uses hands well ____Transfers independently
____Walks independently ____Uses hands fairly well ___Stands with help
____Stronger Left/ Right side ____Does not use hands ____Cannot stand/ walk

Mobility aids used by participant are:_____
(Cont.)

Social Skills: Does participant typically cope well with new people and new situations? YES NO

Has the participant ever taken adaptive horseback riding classes before? YES NO

If so, where? _____

Does the participant exhibit any behaviors which may affect his/her ability to benefit from our program or to work with an Instructor or volunteers in a group setting? Please explain.

_____

Does the participant have any fears we should know about (animals, heights, falling, loud noises, etc.)

_____

Health History: Please indicate if the participant has any current or past problems in the following areas. Please explain any Yes answers.

Health Area	Yes	NO	Comments
Heart/Circulation			
Breathing			
Asthma			
Chronic Pain			
Skin Ulcers			
Vision			
Bone/Joint			
Allergies			
Behavior			

Does the participant have any other medical conditions we should be aware of?

_____

_____

To the best of my knowledge, I confirm that the information I have provided is true and correct at this time.

_____ **Date**_____

Participant, Parent, or Legal Guardian

PHOTO RELEASE

I **DO / DO NOT** (circle one) consent to and authorize the use and reproduction by Front Range Exceptional Equestrians of any and all photographs and other audiovisual materials taken of me/ my child/ my ward for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the Front Range Exceptional Equestrians program.

_____ **Date**_____

Participant, Parent, or Legal Guardian

Everyone must complete and sign these releases before participating in our program. If you are under 18, a parent or guardian must sign.

EMERGENCY TREATMENT INFORMATION

Participant Name_____

Parent/Guardian Name (if minor)_____

Address_____

Phone (Day)_____ Evening_____

Whom shall we call in case of emergency during time at Front Range Exceptional Equestrians:

Name_____ Phone_____

Second contact person:

Name_____ Phone_____

LIABILITY RELEASE

WARNING: Under Colorado law, an equine professional is not liable for an injury to or death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to Section 13-21-119 Colorado Revised Statutes.

_____(Name) requests participation in the Front Range Exceptional Equestrians adaptive horsemanship program. I acknowledge the risks and potential risks of injury during adaptive horsemanship, riding and working with horses. However, I feel that the possible benefit to myself/ my child/ my ward warrants assumption of these risks. I hereby, intending to be legally bound, for myself, my heirs, and my assigns, executors and administrators, waive and release forever all claims for damages against Front Range Exceptional Equestrians, its Board of Directors, Instructors, Therapists, Aides, Volunteers, Horse Owners, Property Owners, and/or Employees for any and all injuries and/or losses that I/ my child/ my ward may sustain while participating in Front Range Exceptional Equestrians adaptive horsemanship program.

_____ _____

Signature of person releasing liability **Date**

_____ _____

Print Name **Relationship to Participant**

Front Range Exceptional Equestrians

Phone (970) 443-5124 PO Box 272452 Ft, Collins, CO 80527-2452

PARTICIPANT'S MEDICAL HISTORY/PHYSICIAN'S CONSENT

Today's Date_____

_____ _____ _____

Participant's Name | Participant's DOB | Primary Contact Name/Phone

_____

Residence Address | City, State, ZIP

_____

Mailing Address (Indicate if Same as Residence) | City, State, ZIP

This Section to be completed by the Primary Care Physician

Primary Diagnosis/Disability_____ Patient's Current Height_____

Patient's Current Weight_____

Medications:_____

Does the patient have Seizures? Y N Type?_____ Controlled? Y N
Date of last _____
Does the patient have a Shunt? Y N Date of last Revision_____

Please indicate any past or present special needs in any of the following areas:

__Auditory impairment __Learning disability __Chronic pain
__Speech impairment __Mental impairment __Spinal injury Level:_____
__Visual impairment __Psychological/ Emotional impairment __Laminectomy/fusion Level_____
__Sensory/ Tactile Defensiveness __Hydrocephalus __Spinal abnormality
__Allergies/asthma __Cardiac disease __Osteoporosis
__Pulmonary disease __Circulatory problems __Cranial defects
__Diabetes __Hemophilia ___Skin Breakdown/ Grafts
__Amputation __Subluxating/dislocating joints Other:_____
__Fractures __Arthritis/joint disease Other:_____
__Scoliosis Degree and type_____

__Kyphosis/lordosis: Degree and type_____

__Recent or Prospective Surgery_____

Patient achieves mobility by (check all that apply): ___Independent ambulation ___Wheelchair ___Walker ___Electric wheelchair ___Crutches ___Braces ___Cane Other

_____
Type(s) of prostheses/orthotics used by patient:

(Health History and Physician's Consent Cont.)

Are there any other special precautions or needs of this patient you would like to advise us of at this time?

_____

If Diagnosis is Down Syndrome, rider must have cervical x-ray for Atlantoaxial subluxation after age 3.
X-Ray Result: Positive Negative Date of X-ray_____

Are symptoms of AAI present now? Y N

I have examined_____ and I certify that there are no signs of change or decrease in neurologic function at this time.

Physician initials_____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand Front Range Exceptional Equestrians will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Front Range Exceptional Equestrians for ongoing evaluation to determine eligibility for participation in equine assisted activities.

Signature of Physician_____

Physician's Name (please Print)_____

Date_____

Office Phone Number_____

Office Address, City, State, and Zip

Front Range Exceptional Equestrians

Phone (970) 443-5124 PO Box 272452 Ft. Collins. CO 80527-2452

CONTRAINDICATIONS and PRECAUTIONS to Adaptive Horseback Riding

Any prospective participant having any of the following contraindications may not be allowed to participate in lessons/classes due to the risk of severe injury or death because of their condition. Any participant the staff feels is not completely competent or that they do not feel comfortable and safe working with, or who demonstrates grossly disruptive behavior. Any participant having any of the following precautions/ contraindications must be evaluated to determine if a safe and beneficial riding experience can be provided for them. All clients must have their physician's permission to participate.

Contraindications

ORTHOPEDIC

Coxa arthrosis (degeneration of hip joint, hip dislocation, subluxation, dysplasia with significant restriction or asymmetry of hip abduction and ROM)
Pathological fractures
Osteoporosis—moderate to severe
Spinal fusion-organic or operative, with insufficient spinal mobility
Atlantoaxial Instability **(See note below)**
Spinal Instability producing excessive uncontrolled head and neck movements
Internal Spinal Stabilization Devices
Structural Scoliosis greater than 30 degrees

NEUROLOGIC

Spina Bifida (Hydromyelia, Chairi II Malformation, Tethered Cord**)**
Spinal Cord Injury above T6
Seizure Disorders (Uncontrolled Grand Mal type)
Hydrocephalus/Shunt with poor head control
Complete quadriplegia secondary to spinal injury

MEDICAL/SURGICAL

Acute arthritis
Acute Multiple Sclerosis
Agitation with severe confusion
Recent surgery
Anti-coagulant medication
CVA secondary to unclipped aneurysm or similar conditions
Open decubital ulcer/wound on weight bearing surface
Excessive kyphosis, lordosis or hemi vertebrae with decreased spinal mobility
Drug dosages causing physical symptoms
Unstable spine for any reason
Rider body weight exceeding 200 pounds

Precautions

All conditions listed above can also fall into this category depending of the severity of the condition and current treatment. Each client/rider will be evaluated on an individual basis to determine if a safe and beneficial riding experience can be provided for them. In addition, the following conditions should also be considered precautions to adaptive horsemanship and riding:

Allergies/ Asthma (horse hair, hay, dust, etc.)
Abnormal fatigue
Age-related considerations
Behavior
Cancer
Diabetes
Hypertension
Heart /cardiac conditions
History of skin breakdown
Incontinence
Obesity
Peripheral vascular disease
Poor endurance
Varicose veins
Recent surgery
Substance abuse
Recent dorsal rhizotomy (3 months-1 year)
Skin grafts
Sensory deficits
Indwelling catheters

****All riders with Down Syndrome must be examined by a physician knowledgeable about Atlantoaxial instability (AAI). The exam must include full extension and flexion x-rays of the neck. The results of the x-ray and examination must demonstrate that the individual does not have the Atlantoaxial instability condition. The rider with Down Syndrome must also provide information from his/her physician annually, clearly indicating the absence of neurologic symptoms by clinical exam.**

Payment

Invoices for each session will be issued one week prior to the start of the session. To ensure continued participation, payment must be received by FREE before the beginning of the second class of the session. Payments can be made online, by mail to FREE's post office box or placed in the mailbox on the reception desk at Temple Grandin Equine Center. Please do not give payments to the instructors.

If any of the following apply to you, please mark

_____ **I am applying for a scholarship and have the Scholarship Application already**

_____ **I would like to apply for a Scholarship, and would like the Scholarship application sent to me at the following email address** _____

_____ **I have funding through Foothills Gateway and would like FREE to invoice them directly.**

_____ **Please send me a receipt to the following email**_____

_____ **Please mail the receipt to the address indicated on this Participant Application**

_____ **I Do Not need a receipt**

REMEMBER
HAVE YOU COMPLETED THE FOLLOWING?

Rider's Medical History/ Physician's Consent (form is signed by Physician)	**YES**	**NO**
Rider Application/Health History (form is signed and dated)	**YES**	**NO**
Emergency Treatment Information	**YES**	**NO**
Liability Release (form is signed and dated)	**YES**	**NO**
Photo Release (form is signed and dated)	**YES**	**NO**
Areas of Learning/ Goal Sheet	**YES**	**NO**

WHEN ALL FORMS ARE SIGNED AND COMPLETED PLEASE RETURN by email to jessie.butler@frontrangeexceptionalequestrians.org or return by mail to:

Front Range Exceptional Equestrians
PO BOX 272452
Fort Collins, CO 80527-2452
Contact Us at: 970-443-5124 with any questions

We are excited for you to be joining us for Adaptive Horsemanship Lessons! YOU WILL BE CONTACTED to arrange a "meet and greet" for orientation and introductions at the barn.

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Areas of Learning & Goals

Date_____ RIDER'S NAME: _____ Age:_____

Rider, Parent, Guardian:

Adaptive Horsemanship provides participants an opportunity to enhance their well being in many ways. Several areas are listed below which indicate the potential benefits. Please indicate and describe the specific areas of learning you or your participant are interested in working on during this riding session. A member of our staff will discuss these and set some goals with you.

Previous or current speech, occupational, and physical therapy_____
_____
_____

Names of therapists_____
_____
_____

COGNITION/PERCEPTION (-attention, following directions, memory, processing sensations such as vision, touch, hearing, movement)
_____
_____
_____

PHYSICAL (posture, balance, strength, coordination, muscle tone)
_____
_____
_____

EDUCATIONAL (learning riding skills, and about horses; grooming, tack)
_____
_____
_____

RECREATIONAL (fun, socialization, self esteem)
_____
_____
_____

COMMUNICATION (skills such as understanding others and expressing oneself)
_____
_____