Back Bay Therapeutic Riding Club Inc.

20262 Cypress Ave. Newport Beach, CA 92660
949-474-7329 www.backbaytrc.org

BACK BAY THERAPEUTIC RIDING CLUB
RIDER REGISTRATION/HEALTH HISTORY/RIDER PROFILE
(UPDATED ANNUALLY)

Name of Participant: _____

Parents/Guardian (if applicable): _____

Address: _____City: _____ Zip: _____

Home Phone:_____ Cell Phone: _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Parent Occupation and Employer:
Father: _____ Phone:_____
Mother:_____Phone:_____

Rider:
Participant Occupation/School and Level: _____
Participant DOB: ____/_____/_____ Sex: _____ Height: _____ Weight: _____Lbs

Diagnosis: _____ Date of Onset: _____

Hospitalization/Surgery (date & reasons): _____
_____

Past Health History: _____
_____

Recent Changes in Health History: _____
_____

Is a seizure disorder present? ☐No ☐ Yes, seizure type: _____ Date of last seizure: _____

Other therapies (type and frequency):_____
_____

Communication: ☐ verbal ☐ non-verbal, communication methods: _____
Behavior issues: _____
_____

Medications (current): _____
_____

Precautions/restrictions:_____

_____

_____

Rider's life goals (examples : improve walking, speaking, self-esteem, having friends, recreation, sport, stretching, ride a bike, be independent, distinguish right from left, sense of safety, decrease anxiety, get dressed him/herself, learn alphabet, count, find a job, etc.)

Short-term goals:_____

Long-term goals: _____

_____ ____/_____/_____

Signature of parent, participant or guardian **Date**

To be filled by BBTRC instructor:

Recommended horse(s): _____

Tack and equipment:

Helmet (*has to be ASTM-SEI approved for equestrian use*) : ☐ Own, if not, center's # or size:_____

Saddle: ☐ pad+surcingle ☐ English saddle ☐can ride both

Reins: ☐ halter+reins ☐ regular bridle

Ability level (circle appropriate skill level):

Mount: ☐croup ☐crest ☐other: Dismount: ☐croup ☐crest ☐other:

From the: ☐ ramp ☐ground To the: ☐ ramp ☐ground

Assistance needed:

Sitting trot: introduced in progress mastered comments:_____

Posting trot: introduced in progress mastered comments:_____

Diagonals: introduced in progress mastered comments:_____

Canter: introduced in progress mastered comments:_____

Steering/reins: introduced in progress mastered comments:_____

Volunteer needs:

Walk only: none spotter leader 1sidewalker 2sidewalkers

Walk/trot: none spotter leader 1sidewalker 2sidewalkers

Additional specific skills learned : _____

Games played in lessons, favorite ones: _____

Additional information: _____

_____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Print Participant Name _____Date Of Birth_____
Print Parent/Guardian Name (If Applicable)_____Address_____
_____
City _____ State _____ Zip__ _____
Home Phone _____ Work Phone__ _____
In The Event I Cannot Be Reached:
Contact _____ Phone _____
Alternate Contact ____ _____ Phone _____
Physician's Name ____ _____ Phone _____
Preferred Medical Facility _____ _____ Phone _____
Health Insurance Co. _ _____ Phone _____
List all pertinent medical information (allergies to food or drugs, medications being taken, special medical conditions: _____
_____
_____

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 the **BACK BAY THERAPEUTIC RIDING CLUB, 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.

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 listed is unable to be reached.

DATE _____ CONSENT SIGNATURE _____
Print Name and Relationship_____

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 **BACK BAY THERAPEUTIC RIDING CLUB, INC.,** In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____
_____
_____

DATE_____ CONSENT SIGNATURE_____
Print Name and Relationship_____

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RELEASE AND HOLD HARMLESS AGREEMENT

The program at the **BACK BAY THERAPEUTIC RIDING CLUB, INC.** provides therapeutic horseback riding for disabled children and adults. Volunteers and horses are carefully selected and trained and safety equipment is required for all riders since horseback riding is a risk exercise.

No student will be accepted for riding instruction and no volunteer accepted for service until this form has been **READ, UNDERSTOOD, COMPLETED AND SIGNED** by the parent(s) or guardian(s) of a minor, or if the student or volunteer is of legal age and sound mind, by the student or volunteer.

Although participation in the program is under strict supervision and every effort is made to avoid injury or accident, the undersigned acknowledges the inherent risks involved in riding and working around horses. This includes bodily injury from horseback riding or being in close proximity to horses. Among other risks, both horse and rider can be injured in normal use or in competition and schooling. In order to provide this valuable service, **NO LIABILITY** can be accepted by the **BACK BAY THERAPEUTIC RIDING CLUB, INC.** or any of the organizations or persons connected with the above named facility.

IN CONSIDERATION, for the privilege of riding and/or working around horses at the **BACK BAY THERAPEUTIC RIDING CLUB, INC.,** the undersigned, as self, or as parent(s) or guardian(s) of the undersigned minor, jointly and severally, do hereby agree to release, hold harmless and indemnify the **BACK BAY THERAPEUTIC RIDING CLUB, INC.,** its officers, directors, trustees, agents, employees, representatives, successors and assigns, from all manner of liability, loss, costs, claims, demands and damages of every kind and nature whatsoever, including but not limited to reasonable attorneys fees, which the undersigned or said minor may now or in the future have against the **BACK BAY THERAPEUTIC RIDING CLUB, INC.,** its officers, directors, trustees, agents, employees, representatives, successors and assigns, on account of any accident, damage, injury or illness, physical or mental condition, known or unknown, to the undersigned or said minor, or the treatment thereof, arising as a result of, or in any way connected to acts or incidents occurring at or relating to the **BACK BAY THERAPEUTIC RIDING CLUB, INC.,** it's officers, directors, trustees, agents, employees, representatives, successors or assigns, including but not limited to their negligence or gross negligence in rendering the services described above or in anyway incidental thereto.

Date_____Participant Name (Print)_____

Participant or Parent/Guardian Signature_____

Print Parent/Guardian Name (If Applicable)_____

Relationship to Participant_____

Address_____

City _____ State_____ Zip_____

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PHOTO AND RESEARCH DATA RELEASE

Print Participant's Name_____

Print Parent/Guardian Name (If Applicable)_____

Address _____

City _____State_____ Zip Code _____

CONCENT TO PHOTO RELEASE

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to the **BACK BAY THERAPEUTIC RIDING CLUB, INC.,** permission to take or have taken still and moving photographs and video, including television pictures, of my/our self-daughter-son-ward_ _____(participant's name) and consents and authorizes the **BACK BAY THERAPEUTIC RIDING CLUB, INC.,** to use and reproduce the photographs, videos and pictures and to circulate and publicize the same by all means including, but not limited to, newspapers, television/social media (Facebook, Instagram…), club's website, brochures, pamphlets, instructional material, books and clinical material.

With respect to the foregoing matters, no inducements or promises have been made to me/us to secure my/our signature(s) to this release other than the intention of the **BACK BAY THERAPEUTIC RIDING CLUB, INC.,** and its work.

SIGNED _____ DATE _____

Relationship to Participant_____

I DO NOT CONSENT TO THIS PHOTO RELEASE (check box) ☐

RESEARCH DATA RELEASE

The undersigned hereby grants permission to use all test results and scores obtained from evaluations, both formal and informal of my/our self-daughter-son-ward_____ (Participant's name) while said was in attendance at **BACK BAY THERAPEUTIC RIDING CLUB, INC.** The material will be used for the purpose of research to be conducted by the above named facility's staff and/ or consultants.

With regard to the foregoing statements, no use of the above named participant will be included in published material. No promises have been made to me/us to secure my/our signatures to this release other than the intention of the above named facility to use the test results and scores obtained from evaluations for the purpose of educational work and research.

SIGNED_____DATE_____

Relationship to Participant _____

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Weight limit policy

At Back Bay Therapeutic Riding Club, safety is our primary concern. We must insure the health and wellness of our participants, volunteers, instructors, and horses as mandated by PATH Intl. Horses are selected for participants based on a rider's skill set, stability on the horse, equipment available, appropriateness of volunteers available, horse conformation and movement, and rider's weight.

BBTRC has maximum weight limits of 200lbs for balanced and/or independent riders and 140lbs for unbalanced and/or supported riders.

The BBTRC is unable to accommodate unbalanced and/or supported riders above 140lbs. An unbalanced and/or supported rider is an individual who may demonstrate one or several of the following: chronic leaning to one side, unable to consistently sit astride a horse without support, needs help supporting the upper body, needs physical assistance during the mount or dismount, needs physical assistance during an emergency dismount (or is unable to consent to the risks of being unassisted during an emergency), is easily left behind the horses movement, etc.

All individuals in riding program will be evaluated to ensure the safety of their participation in mounted activities or therapies. Among the factors to be considered will be the availability of appropriate horses, volunteers, and tack. Please note that the herd, volunteers, and tack at BBTRC is dynamic and due to this fact, we may not always have horses, tack, or volunteers available to safely accommodate every individual who wishes to participate.

NAME _____

SIGNED_____DATE_____

Relationship to Participant _____

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POSSIBLE REASONS FOR PATIENT/CLIENT DISCHARGE

Please be advised of the following reasons that may lead to discharge from the therapy program and/or from the BACK BAY THERAPEUTIC RIDING CLUB. The duration of therapy treatment time is variable, however at some point **all clients will be discharged from therapy**. It is determined at the time of discharge from the therapy program options to transfer to sport riding program or the possible discharge from the Back Bay Therapeutic Riding Club entirely.

1. Patient/client has reached all their goals!
2. Patient's/client's potential to maintain head and neck control in sitting presents a safety concern.
3. Inability to follow directions is interfering with progress toward treatment goals.
4. Uncontrolled and inappropriate behavior that constitutes a safety risk to patient/client and/ or staff.
5. Patient/client exceeds weight that can safely be managed by staff, volunteers, and/or therapy horses.
6. Any change in the patient's/client's medical, physical, cognitive, or emotional condition that makes hippotherapy or therapeutic riding inappropriate.
7. Three scheduled sessions are missed without prior canceling, at the discretion of the treating therapist and/or instructor.
8. Non payment of billed funds after 90 days.

Signature of Patient/Client or Legal Guardian: _____Date:_____

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Dear Physician:

One of your patients is interested in therapeutic horseback riding lessons. Each new student must submit a completed physician assessment form in order to enroll in our program. Your completion of this form will assist our therapists and instructors in designing an individual lesson plan for your patient that is both safe and effective.

Please make special note of any precautions/contraindications that may exist.

Therapeutic riding enhances the quality of life for many children and adults with physical, cognitive or psychological disabilities. Your participation in our program is invited. Please feel free to call or visit if you would like more information.

Sincerely,

Bernadette Olsen
Founder/Executive Director/Advanced Therapeutic Riding Instructor

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PHYSICIAN ASSESSMENT

PATIENT'S NAME_____
PARENTS/GUARDIAN_____
ADDRESS_____
DATE OF BIRTH_____HEIGHT_____WEIGHT_____

DIAGNOSIS_____DATE OF ONSET_____
HOSPITALIZATION/SURGERY(Dates & Reasons)_____
_____
_____
MEDICATIONS_____

SHUNTS/IMPLANTS/APPLIANCES_____

MOBILITY ASSISTING DEVICES_____

IS A SEIZURE DISORDER PRESENT?_____
SEIZURE TYPE_____DATE OF LAST SEIZURE_____

PLEASE INDICATE AND COMMENT ON ANY SPECIAL PROBLEM AREAS BELOW:

AREA	YES	NO	COMMENTS
AUDITORY			
VISUAL			
SPEECH			
CARDIAC			
CIRCULATORY			
PULMONARY			
NEUROLOGICAL/SENSATION			
MUSCULAR			
ORTHOPEDIC **(Note Hip Sublux.)**			
BOWEL/BLADDER			
ALLERGIES			
COGNITION			
PSYCHOLOGICAL			
BEHAVIOR			
OTHER			

PLEASE INDICATE ANY SPECIAL PRECAUTIONS/CONTRAINDICATIONS TO THERAPEUTIC HORSEBACK RIDING_____
_____

FOR PERSONS WITH DOWN SYNDROME – A CERVICAL X-RAY TO EXCLUDE ATLANTOAXIAL INSTABILITY IS MANDATORY:
X-RAY DATE_____RESULTS_____

PHYSICIAN SIGNATURE_____DATE _____

PHYSICIAN NAME/ADDRESS/PHONE (PLEASE PRINT OR USE STAMP):

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PHYSICIAN RELEASE

To my knowledge there is no reason why _____(participant's name) cannot participate in supervised equestrian activities. However, I understand that the Back Bay Therapeutic Riding Club will weigh the medical information above against any existing precautions and/or contraindications before accepting this person for therapeutic horseback riding lessons. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. Physical Therapist, Occupational Therapist. Psychologist, etc.) in the implementing of a safe and effective equestrian program.

PHYSICIAN SIGNATURE _____DATE _____

PHYSICIAN NAME/ADDRESS/PHONE (PLEASE PRINT OR USE STAMP):

_____

_____

_____

STAMP _____