Riverside Ranch
Therapeutic Riding Program

221 Clark Pond Rd.
Clayton, NC 27527

(980) 322-7301
Email:riversideranchnc@gmail.com

Please fill out the following information to assist us in serving you or your child while they are enrolled in the Riverside Ranch Therapeutic Riding Program. If any information is not applicable, simply answer N/A. You may also attach a copy of the therapist's goals.

Rider's name : ___________________________ Phone Number:______________________________

Email: _________________________________ Home phone number:____________________________

Home address: ____

DOB: ________________________ Diagnosis: ____

Parent/Guardian names/phone #:
____

Parent/Guardian place of employment:
____

Precautions:
____
____

Current medications: ____

Current school: ____

Physician name: ____
Phone number: _____________________

Physical Therapist name: __________________________
Phone number: _______________________
Current PT goals:
____
____
____
____

Occupational Therapist name: _______________________
Phone number: ___________________
Current OT goals:
____
____
____

Speech Therapist name: _______________________
Phone number: _____________________
Current Speech goals:
____
____
____

Is there any other information that you feel would help us to work with you or your child (i.e. behavior issues, favorite songs or activities, fears, etc.)?

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Confidentiality Policy

Because of the nature of the program, Riverside Ranch Therapeutic Riding Program may have access to confidential medical and financial records of riders. To protect the confidentiality of our riders, Riverside Ranch has instituted a confidentiality policy. Riverside Ranch Therapeutic Riding Program shall preserve the right of confidentiality for all riders participating in its program. Individuals bound by this policy include part and full time staff members, volunteers who may have access to confidential knowledge, independent contractors involved with the program, instructors and board members. Individuals subject to this policy shall keep confidential any and all medical, social, referral, personal, and financial information regarding a person and/or his or her family. All riders or rider parent(s), legal representatives, or others as defined by state stature must sign consent or non-consent release forms regarding medical and sensitive information disclosure, and consent or non-consent release forms regarding use of photography and/or videotape prior to participation in the program. Penalties for breach of confidentiality shall include the immediate loss of any responsibilities that would allow the individual access to confidential records. Additional penalties may include, at the discretion of the board of directors, reprimand, loss of certain job responsibilities, and/or termination from the program.

I understand and will observe the confidentiality policy of Riverside Ranch.
Date:___/___/_____
Signature:____

I understand that the medical, financial, social, referral, and personal information about me/my son/my daughter or my ward that Riverside Ranch may have on record will be kept confidential as outlined in the confidentiality policy above. However, I hereby consent to and authorize the disclosure by Riverside Ranch to its volunteers any medical information that Riverside Ranch believes is necessary for volunteers to know for the safety of the rider and/or the volunteer.

Date:___/___/_____
Signature:____

READ CAREFULLY BEFORE SIGNING.
THIS IS A BINDING CONTRACT THAT AFFECTS YOUR LEGAL RIGHTS

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LIABILITY RELEASE

I recognize that participation in the activities in the Riverside Ranch program located at 221 Clark Pond Rd. Clayton, NC 27527 ("the facility") involves significant hazards and risks in riding and handling horses. I certify that neither I nor the participant for which I am responsible has any physical conditions which might interfere with my/his/her capacity to participate in horseback riding and other activities offered by the Riverside Ranch program. Knowing the inherent risks, dangers and rigors involved in horseback riding and other activities involving horses, I assume full responsibility for myself or the participant for which I am responsible for any and all bodily injury, death, loss of personal property and expenses thereof, which may occur as a result of participation in the handling of horses, horseback riding and other activities sponsored by the Riverside Ranch program or may occur at the facility. I waive any and all claims which may result from any such participation. I expressly release and waive all such liability and claims, even if they should arise out of the negligence of other persons, including other persons released hereby. I further agree that if anyone makes any claim on my behalf or on behalf of the participant for which I am responsible because of any injury, death or damage to property, I will indemnify and hold harmless all of those persons released by this agreement against any damage, or costs which may result because of those claims, including legal fees.

I will observe all rules, regulations and instructions of the facility and will exercise due care to avoid injury, damage or loss to person and property. I certify that I have received a copy of the current rules and policy and understand that any infractions of the rules may terminate any business I have with the program or right to participate in the program.

The persons and entities which are hereby released and to which the benefit of this liability and release adheres are Riverside Ranch, Inc. and its employees, volunteers, participants, guardians, officers, directors and any other person connected to or participating in the Riverside Ranch program.

I have read, understand and agree to the terms and conditions stated herein. I acknowledge that this agreement shall be effective and binding upon me and the participant for whom I am responsible during the entire period of my/his/her participation in the handling of horses and/or the participation and therapeutic riding lessons upon the premises of the facility.

The undersigned understands that under North Carolina Law an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting exclusively from the inherent risks of equine activities. Chapter 99E of the North Carolina General Statutes.

Signature of participant or parent/guardian if under 18.
This ___________ day of _______________________ ,20_______.

____Participant

____Print name

____Parent/Guardian witness

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Please sign one or the other:

Rider Photo/Video Release

Consent Plan

I consent to and authorize the use and reproduction by Riverside Ranch of any and all photographs and any other audio-visual materials, including videotape, taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Date:___/___/_____ Consent
Signature:____

Non-Consent Plan

I do not give my consent nor do I authorize the use and reproduction by Riverside Ranch of any photographs or any other audio-visual materials taken of me.

Date:___/___/_____ Non-Consent
Signature:____

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Participant's Medical History & Physician's Statement

Date:____________________

Dear Healthcare Provider:

Your patient,
____
(participant's name)
is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests 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 equine activities. 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 Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/
Tethered Cord/Hydromyelia

Other
Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/phone indication above.

Sincerely,

Sarah Valentine
Executive Director

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Participant's Medical History & Physician's Statement

Participant:________________________________ DOB:_______
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:_________________________________
Special Precautions/Needs:____
____
Mobility: Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N
Braces/Assistive Devices:____

We must have a documented height/weight to match our riders to an appropriate horse.
Height: _______________ **Weight:** __________________ **Dr. Initials**: __________

Please indicate current of past special needs 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			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

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To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH center 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Name/Title:____ MD DO NP PA Other________

Signature:____

Date:_________________

Address:____

Phone: ( )___________________________________ License/UPIN Number:__________________