4:13 Therapeutic Riding Association Participant Application and Medical History Form

Rider's Last Name:_____ Rider's First Name:_____

Session (Fall 1, Fall 2, Spring 1, Spring 2, Summer Camp):_____ Date:_____

Parent/ Guardian: _____

Rider's address: _____

_____

Parent/ Guardian Address (if different from above) _____

_____

Phone: home_____ work_____

cell_____ e mail _____

Emergency Contact: Name:_____ phone:_____

Rider's date of birth:_____ Age:_____ Height:_____ Weight:_____

Rider's Alberta Health Care Number _____

Health Insurance Company:_____ Policy # _____

Physicians Name:_____ Tel:_____

Physicians Address: _____

Preferred Medical Facility: _____

Has your physician completed the physician referral form* (next pages) regarding specific participation in horseback riding activities?

Yes_____ **Date:** _____

Diagnosis:_____

_____

Allergies (medical and environmental):

_____

_____

Psycho/Social Function (Work/School grade completed, leisure interests, relationship family structure, support systems, companion animals,fears/concerns):

_____

_____

Goals (why are you applying for participation ? what would you like to accomplish ?):_____

_____

_____

In order to make this a fun and positive experience for each participant, please add any information on their likes/dislikes or any information you believe would be helpful.

_____

_____

_____

_____

Conditions of Registration:

1. Payment in full must be made at time of registration via E-transfer to info@413therapeuticriding.com – Auto Deposit. *Please Note Participant Name and Session in Memo*
2. Cancellation Policy: Fees are 100% non-refundable and non-transferable*.
3. Due to the nature of the riding program please include a doctor's note with your registration documents stating that it is safe for student to participate in horse backing riding activities.
4. Four: Thirteen Therapeutic Riding Association (4:13) and High Country Equestrian Center (HCEC) and individuals that represent them reserve the right to arrange for any special service, obtain and approve any medical attention deemed necessary in the best interest of the participants. Hereby guardian agrees to pay in full all costs of such event.
5. The participant/Guardian agrees to thoroughly read, understand and sign a "Waiver of Release" of 4:13/ High Country Equestrian Center prior to participating in this horse activity.
6. *All students will undergo an assessment to evaluate their suitability for this program. If for any reason the instructor finds the student unable to participate, a full refund will be given.

Participant Name:_____

Participant/ Guardian Signature:_____ Date: _____

Please send completed form to info@413therapeuticriding.com

*PHYSICIAN'S REFFERAL FORM

To be completed by the riding applicant's attending physician. Review Contraindications and Precautions for Therapeutic Riding

PLEASE FILL OUT THE FORM IN DETAIL. ALL INFORMATION IS RELEVANT AND IMPORTANT!

Name:_____ Date of Birth: _____

Height:_____ Weight:_____ Gender: Male ☐ Female

Primary Diagnosis:_____ Onset: _____

Secondary Diagnosis:_____ Onset: _____

Impairment	Normal/Abnormal	If Abnormal, please be specific in comments
Auditory		Assistive Devices:
Speech		Assistive Devices:
Oral Motor Function		
Vision		
Sensation		
Circulatory		
Cardiac		
Respiratory		
Incontinence		
Shunt		
Diabetic	YES/NO	TYPE:
Behavioral or Psychological Concerns		
Spinal/Joint Abnormalities		
Hip Subluxation or Dislocation		LEFT/RIGHT/BOTH

Scoliosis *See contraindications	YES/NO	DEGREE:		
Harrington Rods or Equivalent*	YES/NO	TYPE/DATE/REASON:		
Gross Motor Skills: Upper Extremity Lower Extremity	GOOD	FAIR	POOR	COMMENTS
Fine Motor Skills	GOOD	FAIR	POOR	COMMENTS
Balance: Sitting Standing Dynamic	GOOD	FAIR	POOR	COMMENTS
Muscle Tone: Trunk Upper Extremity Lower Extremity	GOOD	FAIR	POOR	COMMENTS
Pain	YES/NO			
Ambulatory	YES/NO	Please describe Mobility Aids/Devices		
Surgery	REASON/DATE			
Seizure Disorder*	YES/NO	TYPE: DATE OF LAST SEIZURE: MEDICATIONS:		
Down Syndrome*	YES/NO	Requires an Atlanto-Axial X-Ray		
Cerebral Palsy*	Type	Requires additional flexion – extension xray		
* See contraindications. Additional Forms Required. CanTRA Policy available on website				

Allergies	Epinephrine Autoinjector: YES NO Medication:
Immunizations Up to Date	YES/NO
Date of Last Tetanus	

Medications	Dosage	Time	Reason	Side Effects

Have there been any medication changes in the past six (6) months that would affect the Rider's balance orability to ride? YES / NO
(if Yes, please explain): _____

_____

Additional Comments:

Note: Certain disabilities and conditions are contraindicated for riding. Please refer to attached list of contraindications and seizure policy. Are there any other physical, mental health or behavioral issues that we need to be aware of that would affect this individual's enrolment in a therapeutic riding program? IfYes, please explain:

_____

_____

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. I hereby give my permission for the above individual to participate in the therapeutic riding program.

Physician Name:_____Phone: _____

Address: _____

Email:_____

Signature:_____Date: _____

CONTRAINDICATIONS AND PRECAUTIONS FOR THERAPEUTIC RIDING

The following conditions represent precautions or contraindications to therapeutic horseback riding if present in potential participants. Contraindications are symptoms or conditions that are identified as being non beneficial or harmful to a person participating in therapeutic riding. Therefore, when completing the physician's referral, please note whether these conditions are present and to what degree.

ABSOLUTE CONTRAINDICATIONS

ORTHOPEDIC

- Acute arthritis
- Acute herniated disc or prolapsed disc
- Atlanto-Axial Instabilities
- Coxarthrosis (degeneration of hip joint)
- Structural cranial deficits
- Osteogenesis imperfecta
- Pathological fractures
- Spondylothesis
- Structural Scoliosis >30 degrees
- Excessive Kyphosis or Lordosis or Hemivertebra
- Spinal fusion/fixation, Harrington Rod
- Spinal stenosis
- Unable to control trunk &/or neck movement

MEDICAL/PSYCHOLOGICAL

- Obesity or >170 lbs
- Anticoagulants
- Actively dangerous to self or others
- Actively delirious, dissociative, confused

NEUROLOGICAL

- CVA secondary to unclipped aneurysm or angioma
- Paralysis due to spinal cord injury above T6 (adult)
- Spina bifida associations – Chiari II malformation, hydromyelia, tethered cord
- Uncontrolled seizures within the last 6 months

OTHER

- Age under 2 years old
- Any condition that the instructor, therapist, physician or program does not feel comfortable accepting into the program

RELATIVE CONTRAINDICATIONS AND PRECAUTIONS

ORTHOPEDIC

- Arthrogryposis
- Heterotopic Ossification
- Hip subluxation, dislocation or dysphasia
- Osteoporosis
- Spinal instabilities/abnormalities
- Spinal orthoses
- Joint replacement
- Hyper/hypotonia
- Achondroplasia
- Amputations
- Rheumatoid/Osteoarthritis

MEDICAL/PSYCHOSOCIAL

- Abusive or disruptive behaviour
- Cancer
- Hemophilia
- History of skin breakdown or skin grafts
- Incontinence (must wear protection)
- Peripheral vascular disease
- Abnormal fatigue/Poor endurance
- Respiratory Compromised

NEUROLOGIC

- Amyotrophic lateral sclerosis
- Fibromyalgia
- Guillain Barre syndrome
- Myasthenia syndrome
- Lou Gehrigs Disease
- Rett syndrome
- Exacerbation of Multiple Sclerosis
- Post Polio Syndrome
- Hydrocephalus/Hydrocephalic shunt
- Sensory deficits
- Serious heart condition or hypertension
- Significant allergies
- Surgery within the last three months
- Uncontrolled diabetes
- Indwelling catheter
- Myopathy/Muscular Dystrophy (MD)/Spinal Muscular Atrophy (SMA)
- Chronic fatigue immune dysfunction

FLEXION/EXTENSION X-RAY REQUIRED FOR ATRAUMATIC FACTORS THAT MAY BE ASSOCIATED WITH AN UNSTABLE UPPER CERVICAL SPINE

- Down Syndrome
- Os odontoideum
- Athetoid cerebral palsy
- Rheumatoid arthritis of cervical vertebrae
- Congenital torticollis
- Sprengel deformity
- Ankylosing spondylitis
- Congenital atlanto-occipital instability
- Klippel-Feil syndrome
- Chiari malformation with condylar hypoplasia
- Fusion of C2-C3
- Lateral mass degeneration changes at C1-C2
- Systemic lupus
- Morquio disease
- Non-rheumatoid cranial settling
- Subluxation of upper cervical vertebrae due to tumours or infection
- Idiopathic laxity of the ligaments
- Grisel's syndrome
- Lesch-Nyhan syndrome
- Marshall-Smith syndrome
- Diffuse idiopathic hyperostosis
- Congenital chondrodysplasia
- Congenital scoliosis
- Osteogenesis imperfect
- Achondroplasia
- Neurofibromatosis
- Larsen syndrome
- Spondyloepiphyseal dysplasia congenita
- Chondrodysplasia punctata
- Metatropic dysplasia
- Kneist syndrome
- Odontoid abnormalities
- Ossiculum terminale
- Third condyle
- Hypoplasia or absence of the dens
- Pseudoachondroplasia
- Cartilage-hair hyperplasia
- Scott syndrome
- Infections of the head and neck
- Tumors
- Spinal trauma
- Steroid therapy

Four: Thirteen Therapeutic Riding Association is requesting a flexion/extension x-ray for_____to be completed for atraumatic factors that may be associated with an unstable upper cervical spine as per the diagnosis of Athetoid Cerebral Palsy.

Due to the movement patterns and velocity forces the body experiences during acceleration and deceleration while horseback riding, we want to ensure that this is a safe and beneficial activity for _____

Applicant has had a detailed neurological exam	**Yes**	◯	**No**	◯
Applicant has had a flexion/extension x-ray	**Yes**	◯	**No**	◯
A radiologist has determined the cervical spine is stable	**Yes**	◯	**No**	◯

Please attach a copy of the radiologist's x-ray report

Date of X-Ray: _____

Results**:** _____

Applicant's physician has approved riding as suitable	**Yes**	◯	**No** ◯

Please indicate how often this x-ray should be updated:

Yearly_____ **Every 2 Years** _____ **Every 3 Years**_

Other_____

_____ _____ _____

Physician's Name (Print) **Physician's Signature** **Date**

Note: *Due to the nature of this activity, persons diagnosed with Athetoid Cerebral Palsy cannot be accepted for therapeutic riding instruction services without proof of a negative diagnostic x-ray for instability of the cervical spine. This form must be accompanied by a signed and dated statement from a qualified physician giving the date and result of the diagnostic x-ray.*

Additional Release Form for Downs Syndrome Applicants

Regarding: Atlanto-Axial Instability.

Applicant has had a detailed neurological exam	_____YES _____NO
Applicant has had an atlanto-axial x-ray	_____YES _____NO
A neurologist has determined that the gap between C1 and C2 is less than 4.5 mm Please attach a copy of the Radiologist's x-ray report	_____YES _____NO
The applicant's Doctor has approved riding as suitable forthe applicant	_____YES _____NO

Please read & sign:

I would like_____to have riding instruction.

I am aware of the risk and potential for additional risks for riders with Downs Syndrome. I have read the Canadian Therapeutic Riding Association (CanTRA) Policy regarding Downs Syndrome and Atlanto-Axial Instability. I understand that NO LIABILITY can be accepted by any organizations or individuals concerned with this riding instruction; including Four:Thirteen Therapeutic Riding Association and or any one providing facilities, equipment or support. I, hereby intending to be legally bound for myself, my heirs and assigns, executors and administrators, wave and release forever all claims of damage against Four: Thirteen Therapeutic Riding Association, its Board of Directors,Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses the rider may sustain while participating in Four: Thirteen Therapeutic Riding Programs.

Parent/Guardian Signature*	Date
Witness Signature	Date

(*if signed as a parent or guardian of the rider, relationship to the rider must be indicated)

Additional Release Form for Applicants with Seizures

Applicant has been seizure-free for six months while on medication or for one year without medication (Note: Riders with uncontrolled seizures are not permitted to ride)	Yes _____	No_____
Applicant has absence seizures (Note: Riders with absence seizures which do not affect the rider's balance, posture or tone will not be allowed to ride independently but may still be accepted to ride with 4:13 and are subject to 4:13 approval)	Yes _____	No_____
The applicant's Doctor has approved riding as suitable for the applicant	Yes _____	No_____

Please read & sign: I would like_____to have riding instruction.

I am aware of the risk and potential for additional risks for riders with seizures. I have read the Canadian Therapeutic Riding Association (CanTRA) Policy regarding seizures. I understand thatNO LIABILITY can be accepted by any organizations or individuals concerned with this riding instruction; including Four: Thirteen Therapeutic Riding Association and or anyone providing facilities, equipment or support. I, hereby intending to be legally bound for myself, my heirs and assigns, executors and administrators, wave and release forever all claims of damage against Four: Thirteen Therapeutic Riding Association, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses the rider may sustain while participating in Four: Thirteen Therapeutic Riding.

_____

Parent/Guardian Signature

_____

Date

FOUR: THIRTEEN THERAPEUTIC RIDING ASSOCIATION

Degree of Bodily Contact Policy

Policy:

Due to the nature of the work at Four: Thirteen Therapeutic Riding Association, it is understood that instructors and trained volunteers will need to physically assist the majority of riders in one or more of thefollowing areas, and it is understood that this is part of the therapy/recreation session to which riders and parents have consented.

- When mounting, dismounting or riding a horse
- When lifting a rider onto the horse, to correct posture by placing hands at the front or back of the trunk, to correct leg and hand positions
- During riding sessions when having to quickly physically remove a rider from the group due to behavioural or other concerns, and which is done for the well-being of all concerned (this may involve two staff members lifting a rider)

Any bodily contact provided by trained staff or personal care workers is in the interest of providing a safe and fun environment for the rider and will be undertaken with the utmost discretion.
Many of the riders with special needs who attend Four: Thirteen Therapeutic Riding Association like to give hugs. This will be monitored by staff so that other risers, centre personnel or volunteers will not be placed in an embarrassing situation and behaviour will be modified as deemed necessary.

I have read, understood and agree to the term of the policy

Rider Name:_____

Signature:_____ (parent or guardian if rider is under 18)

Name:_____

Date: _____

Witness:_____

4:13 / HCEC PHOTO RELEASE FORM

I, the undersigned,

_____ DO

_____ DO NOT

Consent and authorize the use and reproduction by “Four: Thirteen Therapeutic Riding Association” and“High Country Equestrian Center” of any and all photographs and any other audio/visual materials taken of me for promotion material, educational activities, exhibition or for any other use for the benefit of theprogram.

(18 years and older)
Name of Rider (print): _____
Signature:_____ Date:_____

(If under 18 or guardianship in place)
Name of Rider (print): _____
Parent/Guardian Signature:_____Date:_____
Parent/Guardian Name (print): _____

FOUR: THIRTEEN THERAPEUTIC RIDING ASSOCIATION

Child Participant Release of Liability Agreement

I, (parent/guardian)_____for and in consideration of the agreement for Four: Thirteen Therapeutic Riding Association and High Country Equestrian Center (4:13 and HCEC) to provide Therapeutic Riding and Equine Assisted Activities to my child (name)

_____, do herby forever release, acquit, discharge and hold harmless 4:13 and HCEC, its officers, trustees, agents, employees, representatives, successors and assigns, for all manner of claims, demands, and damages of every kind and nature whatsoever; which the undersigned may now, or in the future, have against 4:13 and HCEC or, its officers, trustees, agents, employees, representatives, successors and assigns on account of any personal injuries including death, physical or mental condition, known or unknown, to the undersigned and the treatment therefore as a result of, or in any way growing out of, the acts of 4:13 and HCEC, its officers, trustees, agents, employees, representatives, successors and assigns, including but not limited to, their negligence or gross negligence,in rendering the services above described in any way incidental thereto.

Signature of Parent/Guardian:_____Date:_____

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 farm, I authorize 4:13 to:

- Secure and retain medical treatment and transportation in needed,
- Attempt to contact parent and guardian, then the emergency contacts in the order listed below.
- Release client records upon request to the authorized individual or agency involved in the emergency medical treatment.

Parent Emergency Contact:_____Tel:_____
Emergency Contact #1_____Tel:_____
Emergency Contact #2_____Tel:_____
Emergency Contact #3_____Tel: _____

Consent Plan

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(s) listed above as emergency contacts are unable to be reached.

Consent Signature (Parent/Guardian):_____Date:_____
Name (printed): _____

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: _____

_____

_____

_____

_____

Consent Signature (Parent/Guardian):_____Date:_____
Name (printed): _____

ASSUMPTION OF RISKS, RELEASE OF INTEREST, WAIVER OF CLAIM, AND INDEMNITY AGREEMENT
BY SIGNING THIS DOCUMENT YOU WILL WAIVE CERTAIN LEGAL RIGHTS INCLUDING THE RIGHT TO SUE.
PLEASE READ CAREFULLY!

Participant Name _____
Address_____
Phone No _____
Program/Purpose of visit: ☐ HCEC Riding lesson ☐ Therapeutic riding lesson ☐ Volunteer ☐ HCEC Employee ☐ Instructor
☐ Other:_____

To: **High Country Equestrian Center** (referred to in this agreement as the "Provider")

AND TO: ALL PROPERTY OWNERS (PRIVATE, FEDERAL, PROVINCIAL, REGIONAL AND MUNICIPAL)

On my behalf, and on the behalf of any minor children participating in these activities, for whom I am legally responsible, I agree to the following:

ASSUMPTION OF RISKS:

I am aware and understood that activities involving horses involve many risks, dangers and hazards, including, but not limited to the following:

1. Horses, which are powerful and potentially dangerous animals, may change their behavior at any time and may, without warning, jump, run wildly, buck, kick, bite or step on people or things:
2. Horses may collide with other horses or objects or trip, stumble or fall even if being led, ridden, or attended to;
3. Negligence (which means, in general terms, a failure to exercise ordinary or proper care) of other riders or my or my child's own failure to ride safely within my or my child's ability or within designated areas and trails;
4. Equipment may fail;
5. Weather conditions can change and can sometimes be dangerous;
6. The nature of the terrain can change and has certain risks associated with it including, but not limited to, exposed natural objects, trees, streams and creeks;
7. The activities can sometimes be in remote areas and injuries or illness may occur and it may be a considerable distance to doctors, hospitals, or any other type of assistance; and
8. Negligence on the part of A PROPERTY OWNER AND/OR THE PROVIDER OR THEIR STAFF.

I am also aware that the risks, dangers and hazards referred to above exist throughout the trail, stable, practice and other areas and many are unmarked. I understand and acknowledge that no amount of caution, experience and instruction can eliminate all of the risks involved and I freely accept and fully assume all such risks, dangers and hazards and the possibility of personal injury, death, property damage and damages or loss resulting there from.

Initials	HCEC Initials

RELEASE OF LIABILITY, WAIVER OF CLAIMS AND INDEMNITY AGREEMENT

In consideration of the Provider providing me or my child with their horses and other services and permitting my or my child's use of their equipment, and other facilities and the Property Owners providing me or my child with the use of their property (hereinafter collectively) referred to as "the Services"), I hereby agree as follows:

1. TO WAIVE ANY AND ALL CLAIMS that I or my child have or may in the future have against a Property Owner or the Provider, and their directors, officers, employees, agents, representatives, and volunteers (all of whom are hereinafter collectively referred to as "THE RELEASEES") and TO RELEASE THE RELEASEES from any and all liability for any loss, damage, injury, illness or expense that I or my child may suffer, or that my or my child's next of kin may suffer as a result of my or my child's use of the services or due to any cause whatsoever, INCLUDING NEGLIGENCE,BREACH OF CONTRACT, OR BREACH OF ANY STATUTORY OR OTHER DUTY OR CARE INCLUDING ANY DUTY OF CARE OWED UNDER THE "OCCUPIERS LIABILITY ACT" ON THE PART OF THE RELEASEES;
2. TO HOLD HARMLESS AND INDEMNIFY THE RELEASEES from any and all liability for any damages to the property of or personal injury to any third party resulting from my or my child's use of the services;
3. This Agreement shall be effective and binding upon my or my child's heirs, next of kin, executors, administrators, assigns and representatives in the event of my or my child's death or incapacity;
4. This agreement shall be governed by and interpreted in accordance with the laws of the Province of Alberta ; and
5. Any litigation involving the parties to this Agreement shall be brought within the Province of Alberta.

Initials	HCEC Initials

PROTECTIVE HEAD GEAR & RIDING BOOTS

1. Proper riding footwear is required by all persons, regardless of age, participating in any horse related activities.
2. ALL MINORS (Horseback riders under 18 years of age) are required to wear protective head gear in the form of a high impact helmet and proper footwear.
3. IT IS HIGHLY RECOMMENDED THAT ALL HORSE BACK RIDERS OF ANY AGE WEAR A HIGH IMPACT HELMET.
4. I (we) decline to wear a helmet(s).

Initials	HCEC Initials

In entering into this Agreement, I am not relying upon any oral or written representations or statements made by the Releasees other than what is set forth in this Agreement. I HAVE READ AND UNDERSTOOD THIS AGREEMENT AND I AM AWARE THAT BY SIGNING THIS AGREEMENT, FROM THIS DAY FORWARD, I AM WAIVING CERTAIN LEGAL RIGHTS WHICH I, MY CHILD, MY HEIRS, NEXT OF KIN, EXECUTORS, ADMINISTRATORS, ASSIGNS AND/OR REPRESENTATIVES MAY HAVE AGAINST THE RELEASEES.

Name_____	Witness_____
Address_____	Address_____
Phone No _____	Phone No _____
Signature_____	Signature_____
Date of Signature _____	Date of Signature_____
(A parent or guardian must sign for children under 18 and/ or legally incapable persons)	

THIS AGREEMENT MUST BE COMPLETED IN FULL, SIGNED, DATED, AND WITNESSED BEFORE ANY ACTIVITY WITH HORSES MAY BE UNDERTAKEN.