RIDER AGREEMENT & REGISTRATION PACKAGE

P.O. Box 1820 205-7th Ave. N. Creston BC, V0B 1G0 ph. 250-402-6793 fax 428-2297

Welcome to CDSCL's Therapeutic Riding Program! We look forward to a wonderful relationship.

This package is designed to guide you through the registration process. Unfortunately, this process involves a lot of forms. Please understand that this paperwork is necessary for the CDSCL Therapeutic Riding Program to be in compliance with insurance requirements. It is also necessary to help the team tailor the lessons to your needs by providing the right combination of horse, equipment, tack, volunteers and lesson content.

Riders cannot participate in any activity at the CDSCL Therapeutic Riding Program without the appropriate forms. We ask that you return all forms as soon as possible – and at least one week prior to the start of lessons to allow the Instructor time to review them and set up an individualized riding program.

Prior to the first session the following forms are required to be returned to the Program Director:

Where applicable and/or required:

- Intake/Referral for Services
- Consent for release of information
- For riders with Down Syndrome - Atlanto-axial X-Ray Verification

Mandatory forms:

- Rider Application/Profile Form
- Liability Waiver
- Photograph/Video Release/Non Consent Form
- Emergency Profile
- Authorization/Non Authorization for Emergency Medical Treatment
- Physician Referral Form

Once registered, the following form will be required to be updated when a rider's condition changes:

- Physician Referral Form

The following will be required prior to each session:

- Session Registration Form

If the rider's condition/situation changes at any time, please let the Program Director know and have the appropriate information updated, or the required form re-submitted.

All forms must be properly filled out, signed and returned to CDSCL before the student may ride.

Prior to a rider's acceptance to the program, there will be an assessment visit with the Instructor and other therapists as required (i.e. Physical Therapist, Occupational Therapist, Counselor etc.). An orientation

visit may be arranged to fit tack, hat and belt; and to familiarize the rider with the program. These 2 visits may be combined.

For the safety of the student, volunteers and horses, some applicants may not be accepted into the program.

FEES & PAYMENT POLICIES

- Sessions must be prepaid in full prior to the start of the session.

LESSON CANCELLATION POLICY*:*

- In the event of cancellation of a lesson by CDSCL, the lesson will be rescheduled.
- If lessons are proceeding as scheduled and the student does not attend, there will be no make-up lesson.

RIDER/CAREGIVER RESPONSIBILITIES:

- It is much appreciated if CDSCL is notified if a rider will not be attending. The program strives to avoid having volunteers with nothing to do and horses tacked up and ready with no rider.
- A caregiver must remain on-site during the lesson unless arranged with CDSCL.
- It is the responsibility of the caregiver to have the student appropriately attired for riding and weather conditions. Boots or shoes with heels and long pants are mandatory. Riders will not be able to participate without the appropriate attire. Pant pockets should be empty of items that might poke the rider during the mount and dismount.

SESSIONS

Therapeutic Riding lessons will be taught by either

- a Canadian Therapeutic Riding Association (CanTRA) Coach
- a CanTRA certified Intermediate Instructor
- a CanTRA certified Basic Instructor
- a CanTRA Basic Instructor Candidate under the supervision of the Coach or Intermediate Instructor.

If necessary (and available), a physical therapist will be utilized during the session. The Instructor will have access to the advice of a number of different types of therapists.

- Lessons will have a maximum group of 4 riders.
- The length of each riding lesson is one half hour. The participant may arrive 30 minutes before their lesson time to help get their horse ready for the lesson and stay 15 minutes after the lesson to help put the horse away, for a total of 1 hour and 15 minutes.
- Lessons with more than one rider may go a little longer to include time for the mounting and dismounting of the riders.

The minimum age for participation in CDSCL's Therapeutic Riding Program at this time is 5 years old.

Classes will be filled on the basis of disability needs, riding ability, volunteer ability and availability as well as horse availability. Please encourage people who are interested in volunteering to contact the Program Director. Lack of volunteers is often the only impediment to proceeding with a class. There is a great need for committed volunteers!!

Admission & Discharge Policy

It is the decision of the Program Director/Instructor/Medical Committee to admit or discharge a rider. Riders can be refused entry or discharge from the program for a variety of reasons including but not restricted to exceeding the weight allowed, failure to appear for classes, inappropriate behavior, or implications that the continuation of therapeutic riding is a contraindication.

While every effort will be made to meet a rider's needs, a rider possessing the ability and desire to advance to a higher level of instruction than the CDSCL Therapeutic Riding Program offers, will be discharged and given assistance in locating a program and/or instructor that meets their needs.

Dress

It is mandatory that all riders, volunteers and staff ride with (ASTM-SEI) helmets.

It is mandatory that hard sole shoes or boots with heels, or safety stirrups be used by all riders, volunteers and staff while riding. Stirrups and footwear must be approved by the Instructor before mounting.

Agreement

I hereby certify that I have read and agree to the above conditions.

Signature of Rider: _____ Date: _____

Signature of Legal Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

CDSCL

RIDER APPLICATION FORM – TO BE FILLED OUT PRIOR TO FIRST SESSION

P.O. Box 1820 205-7th Ave. N. Creston BC, V0B 1G0 ph. 250- 402-6793 fax 428-2297

General Information:

Name: _____ Date: _____

DOB: _____ Height: _____ Weight: _____

Note on Weight: Our status as a CanTRA Accredited centre requires a weight limit of 180 lbs.

Address and Postal Code: _____

Home Phone: _____ email: _____

Employer/School: _____

Work Phone: _____ Cell Phone: _____

Mother's Name _____ Work Phone: _____

Address if different than above: _____

Home Phone: _____ Cell Phone: _____

Father's Name: _____ Work Phone: _____

Address if different than above: _____

Home Phone: _____Cell Phone: _____

Legal Guardian Name: _____ Work Phone: _____

Address: _____

Home Phone: _____ Cell Phone: _____

How did you hear about the CDSCL Therapeutic Riding Program? _____

Rider Profile

Rider has ridden before YES NO With a Therapeutic Riding Program YES NO

How long ago? _____ How long? _____

Is the rider ambulatory? YES NO Verbal? YES NO

If non-verbal, what form of communication does he/she use? _____

Does the rider use any of the following?

Wheelchair YES NO Crutches YES NO Braces YES NO

Walker YES NO Cane YES NO

Is rider able to sit independently? YES NO

What medications are you currently taking, including over-the-counter medications?

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

FUNCTION (i.e. mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

SOCIAL (i.e. work/school including grade completed, leisure interests, relationships, family structure support systems, companion animals, fears/concerns etc.)

GOALS (i.e. why are you applying for participation? What would you like to accomplish?)

Are there any other therapists that are involved with the rider's care that should be part of the Therapeutic Riding team? (i.e. physical therapist, occupational therapist, counselor, chiropractor etc.)

Is there any other information that you feel CDSCL should know?

Signature of Rider: _____ Date: _____

Signature of Legal Guardian: _____ Date: _____

Witness: _____

LIABILITY WAIVER / PHOTO & VIDEO RELEASE

P.O. Box 1820 205-7th Ave. N. Creston BC, V0B 1G0 ph. 250-402-6793 fax 428-2297

Name of Rider: _____

RIDER LIABILITY WAIVER

I acknowledge that the sport of horses is a risk sport and that I am participating at my own risk and in full knowledge of the hazards and potential hazards which are inherent in this sport. I further acknowledge the inherent risk in riding, working around horses (mounted and dismounted) and viewing horse activities, which include bodily injury to both horse and rider which can result from therapeutic riding as well as normal use, competition and schooling. It is hereby also understood that no helmet or protective equipment can protect me against all foreseeable injury.

I hereby assume all risk and hereby absolve Creston and District Society for Community Living, its members and volunteers, Kootenay Region Association for Community Living, their members and volunteers from all responsibility, liability or claims of any nature and kind which I may have arising from participation in the Therapeutic Riding Program including but not limited to bodily injury or death, and damage to or loss of my property arising from any cause whatsoever, including negligence of one or more of the organizations or individuals referred to herein.

I hereby declare that in signing this document that I have read and fully understood and agree to the terms and conditions stated herein and that it is binding upon my executors, heirs and assigns.

Signature of Rider: _____ date: _____

Signature of Legal Guardian: _____ date: _____

Signature of Witness: _____ date: _____

PHOTO/VIDEO RELEASE/NON-CONSENT

While on outings and during our daily programs many exciting situations arise. By photographing or video taping these events we can share them with you, family members, caregivers, and others and utilize them to demonstrate the "good works" for our organization. For this reason, we ask permission to share these photographs and or videotapes with the general public.

Give permission for CDSCL to (please select Yes or No for each item)

1. Share photographs with the general public Yes ( ) No ( )
2. Share video tapes with the general public Yes ( ) No ( )
3. Publish photographs/videos/stories on the internet Yes ( ) No ( )

Signature of Rider: _____ date: _____

Signature of Witness: _____

Signature of Legal Guardian: _____ date: _____

Signature of Witness: _____ date: _____

EMERGENCY MEDICAL TREATMENT

P.O. Box 1820 205-7th Ave. N. Creston BC, V0B 1G0 ph. (250) 402-6793 fax 428-2297

Name: _____

Address: _____

Phone: _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Care Card Number: _____

Physician Name: _____ Phone: _____

Medications: _____

Allergies: _____

Other: _____

PLEASE ONLY SIGN ONE – CONSENT OR NON-CONSENT

CONSENT FOR EMERGENCY MEDICAL TREATMENT

In case of emergency, **I give permission** to Creston and District Society for Community Living to secure medical treatment including x-rays, surgery, hospitalization and medication.

Signature of Rider: _____ Date: _____

Signature of Legal Guardian: _____ Date: _____

Witness: _____

NON CONSENT FOR EMERGENCY MEDICAL TREATMENT

In case of emergency, **I do not give permission** to Creston and District Society for Community Living to secure medical treatment including x-rays, surgery, hospitalization and medication.

Signature of Rider: _____ Date: _____

Signature of Legal Guardian: _____ Date: _____

Witness: _____

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RIDER REPORT SHARING CONSENT/NON CONSENT FORM

P.O. Box 1820 205-7th Ave. N. Creston BC, V0B 1G0 ph. 250-402-6793 fax 428-2297

CONSENT FOR SHARING RIDER REPORTS

I, _____, hereby authorize Creston and District Society for Community Living to share rider reports for _____ who is a participant in the Therapeutic Riding Program.

Signature: _____ Date: _____

Witness: _____

Please provide the name and phone number of the parties with whom we may share rider reports:

Name:	Phone:
Address:	Relationship:
Name:	Phone:
Address:	Relationship:
Name:	Phone:
Address:	Relationship:

NON CONSENT FOR SHARING RIDER REPORTS

I, _____, DO NOT authorize Creston and District Society for Community Living to share rider reports for _____ who is a participant in the Therapeutic Riding Program.

Signature: _____ Date: _____

Witness: _____

CDSCL complies with BC's privacy legislation. Association policies and procedures regarding confidentiality and privacy issues comply fully with the Personal Information Protection Act (PIPA).

CDSCL

PHYSICIAN'S REFERRAL – TO BE COMPLETED BY PHYSICIAN

P.O. Box 1820 205-7th Ave. N. Creston BC, V0B 1G0 ph. 250-402-6793 fax 428-2297

Name: _____ Date: _____

DOB: _____ Sex: _____

Phone: _____ email: _____

Living at Home: _____ Other: _____

Next of Kin/Legal Guardian: _____

Phone: _____ email: _____

MEDICAL

Primary
Diagnosis: _____ Date of onset: _____
Secondary
Diagnosis: _____ Date of onset: _____

Height: _____ Weight: _____

Diabetes: _____ Insulin: _____

Epilepsy: _____ Frequency/type of seizures: _____

Date of last seizure: _____

Medications: _____

For: _____

SURGERY DATES

_____

Ambulatory: YES NO Assistive Devices: _____

PHYSICAL

Muscle Tone (spasticity, flaccidity, etc.)

Tone in upper extremities: _____

Tone in lower extremities: _____

Tone in trunk: _____

Balance: Sitting: _____ Standing: _____ Walking: _____

Scoliosis: Type: _____ Degree: _____

Brace: _____ Last X-Ray: _____

Kyphosis/Lordosis
Type: _____ Degree: _____

Osteoporosis: _____ Arthritis: _____

SENSORY

Language: English: _____ Sign: _____ Other: _____

Comprehension: Good: _____ Fair: _____ Poor: _____

Sensory Function: Sight: _____ Hearing: _____

Tactile: _____ Continence: _____

Allergies/Severity: _____

PHYSIOTHERAPY

Is the patient attending physiotherapy? YES NO

If so, where/who: _____

Precautions to Physiotherapist: _____

REASSESSMENT

When do you recommend this patient be reassessed? _____

PHYSICIAN'S REFERRAL – TO BE COMPLETED BY PHYSICIAN

P.O. Box 1820 205-7th Ave. N. Creston BC, V0B 1G0 ph. 250-402-6793 fax 428-2297

I confirm that there are no current medical concerns to preclude _____ from participating in the Creston and District Society for Community Living Therapeutic Riding Program.

Physician's signature: _____ Date: _____

Physician's name: _____
(Please print clearly)

Physician's address: _____
(Please print clearly)

Phone: _____ email: _____ fax: _____

NOTE:

- A list of **CONTRAINDICATIONS** and **PRECAUTIONS** to therapeutic riding is enclosed for your information.
- A change in medical condition requires a physician referral update.

. . . . . .

EXTENDED PHYSICIAN'S REFERRAL

To: Creston and District Society for Community Living Therapeutic Riding Program

Re: _____

The last medical referral submitted on _____ is still valid.

There have been no significant changes to the condition of the client other than as noted below:

_____

REASSESSMENT

When do you recommend this patient be reassessed? _____

Signature of Physician: _____ Date: _____

Print Name: _____

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CONTRAINDICATIONS TO THERAPEUTIC RIDING

(Please forward with Physician's Referral)

CONTRAINDICATIONS:

If a person has any of the following medical conditions, riding is very unlikely to be a beneficial activity for him or her, and is even likely to be harmful. Before an individual is accepted into the therapeutic riding program, the physician and program therapist should be consulted concerning the suitability of riding for that person. The program reserves the right to determine the candidate's suitability for inclusion in the program.

- Moderate to severe agitation (confusion, excitement) and/or very disruptive behaviour
- Spinal instability, including subluxation (partial dislocation) of cervical (neck) vertebrae
- Severe osteoporosis, involves brittleness of the bones and hence the possibility of fractures
- Seizures which are not controlled by medication
- Pathological fractures arising from a condition such as osteogenesis imperfecta (brittle bones)
- Acute stages of arthritis
- Periods of exacerbation of multiple sclerosis
- Open pressure sores or wounds
- The individual is taking medication in type or dosage that induces a mental or physical state that makes riding risky and/or inappropriate
- Hemophilia, a congenital condition of the blood characterized by hemorrhages (bleeding).
- The individual is taking anticoagulant medications (blood thinners)
- Atlanto-axial instability
- Spondylothesis (subluxation of the lower lumbar vertebra on the sacrum)
- Coxarthrosis (degeneration of the hip joint) – riding causes too much stress on that joint
- Detached retina
- Acute herniated intervertebral disk, which may press on spinal nerve roots
- Complete quadriplegia occurring as a result of a spinal cord injury
- Structural scoliosis greater than 30 degrees, excessive kyphosis (rearward increase of the curvature of the thoracic spine) or lordosis (increased forward curvature in the lumbar spine), or hemivertebra (a congenital defect in which one side of a vertebra is incomplete)
- Dislocation, subluxation or dysplasia (abnormal development) of the hip(s) with significant restriction or asymmetry
- Any condition that the instructor, therapist, physician or program does not feel comfortable treating
- After a rhizotomy, a rider should wait at least 6 months before participating in a riding program

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PRECAUTIONS AND POSSIBLE CONTRAINDICATIONS TO THERAPEUTIC RIDING

(Please forward with Physician's Referral)

If a person has any of the following conditions, riding may not be beneficial, and in some instances, may even be harmful. Before an individual is accepted into the therapeutic riding program, the physician and program therapist should be consulted concerning the suitability of riding for that person. The program reserves the right to determine the candidate's suitability for inclusion in the program.

- Prolonged use of Dialantin
- Incontinence
- Hydrocephalus - presence of shunt(s)
- Sensory deficits – unable to feel certain parts of the body
- Heterotopic ossification
- Significant allergies to horse hair, dust, hay etc.
- Recent surgery **(Riders must have written consent from physician before returning to program)**
- Serious cardiac condition
- Craniotomy (any surgical procedure on the skull)
- Diabetes
- Peripheral vascular disease, resulting in poor circulation in the extremities
- Obesity (See Horse Load Guidelines)
- Extreme fatigue
- Arnold Chiari malformation, a congenital defect in which the cerebellum and medulla oblongata protrude through the skull, down into the spinal canal and which is most often associated with other disabilities such as spina bifida
- Any spinal fusion, whether natural or due to surgical intervention (e.g. Harrington rod)
- History of skin breakdown and/or skin grafts over areas of the body that bear weight in riding (seat and legs)
- Tethered cord
- History of substance abuse which has resulted in fragile blood vessels
- Rhizotomy (a surgical procedure in which the roots of the spinal nerves along the spinal canal are cut)

ATLANTO-AXIAL X-RAY VERIFICATION / DOWN SYNDROME

P.O. Box 1820 205-7th Ave. N. Creston BC, V0B 1G0 ph. 250-402-6793 fax 428-2297

All rider candidates who have Down Syndrome should have a detailed neurological examination before being accepted for riding.

The American Academy of Pediatrics and the Committee on Sports Medicine recommends the following:

1. When an individual is shown, upon x-ray examination, to have a distance exceeding 4.5 mm between the odontoid process of the second cervical vertebra (C2) and the arch of the first cervical vertebra (C1), he or she should restrict sport activities and undergo regular clinical evaluations to monitor the instability.
2. It is not mandatory to regularly examine individuals who have previously been shown, on x-ray examination, to have a normal atlanto-axial joint.
3. People with Down Syndrome who have no evidence of atlanto-axial instability may participate in all sports. Medical follow-up is not required unless an individual experiences musculo-skeletal or neurological signs or symptoms of atlanto-axial instability.

Rider: _____ DOB: _____

Address: _____ Phone: _____

Next of Kin/Guardian: _____ Phone: _____

Date of X-Ray: _____

Result:

_____

Physician's signature: _____

Name of Physician: _____

Phone: _____ fax: _____ email: _____

NOTE: Due to the nature of this activity, persons diagnosed with Down Syndrome cannot be accepted for riding instruction without proof of a negative diagnostic X-ray for atlanto-axial instability.

PHYSICAL THERAPY EVALUATION - OPTIONAL

P.O. Box 1820 205-7th Ave. N. Creston BC, V0B 1G0 ph. (250) 402-6793 fax 428-2297

(Please complete this evaluation as fully as possible to enable us to plan a therapy program which will benefit the individual client)

Name: _____ DOB: _____

Diagnosis: _____

Surgeries Performed (with dates): _____

_____

Other Pertinent Medical History: _____

_____

Muscle Strength:
Gross: _____

Specific Weaknesses: _____

Joint ROM:
Gross: _____

Specific Limitations: _____

Muscle Tone: _____

Balance: Sitting: _____ Standing: _____ Walking: _____

Coordination:
Gross Motor: _____ Fine Motor: _____

Reflex Activity:
Developmental: _____

Tendon reflexes: _____

Pain:
Character: _____ Location: _____

Caused by: _____ Relieved by: _____

Sensory Impairments: _____

Perceptual Problems: _____

Communication Difficulties: _____

Skin Condition: _____

Functional Abilities:
Mobility: _____

Transfers: _____

ADL Skills: _____

	Problem	Plans & Goals
1.	_____	
2.	_____	
3.	_____	
4.	_____	

Additional Comments:

Signature of RPT: _____

Name of RPT: _____

Address: _____

Phone: _____ fax: _____ email: _____