



## 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**

- Costs:
  - Eight Week Session, one lesson per week   **\$ 150**
  - Eight Week Session, two lessons per week   **\$ 300**
- 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) certified Instructor
- a CanTRA certified Intermediate Instructor
- a CanTRA certified Assistant Instructor
- a CanTRA Assistant Instructor Candidate under the supervision of any of the above instructors.

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 lesson is one half hour.
- 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.

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: \_\_\_\_\_



**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?

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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)

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

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

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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.)

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

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Signature of Rider: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_



## VIDEO RELEASE/LIABILITY WAIVER

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

**Name of Rider:** \_\_\_\_\_

### 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.

I, \_\_\_\_\_ of \_\_\_\_\_  
Name Address

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: \_\_\_\_\_

### 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: \_\_\_\_\_



# 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: \_\_\_\_\_



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:

Table with 6 rows and 2 columns. Columns: Name, Address, Phone, 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).





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: \_\_\_\_\_

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**SURGERY**

**DATES**

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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: \_\_\_\_\_ Contenance: \_\_\_\_\_

Allergies/Severity: \_\_\_\_\_

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## PHYSIOTHERAPY

Is the patient attending physiotherapy? YES NO

If so, where/who: \_\_\_\_\_

Precautions to Physiotherapist: \_\_\_\_\_

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## 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 hereby give my permission for \_\_\_\_\_ to participate 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:**

- It is important that this form be filled out in detail (e.g. height, weight, etc.) in order for the instructor and physiotherapist to match the rider with the right horse and appropriate support.
- A list of **CONTRAINDICATIONS** and **PRECAUTIONS** to therapeutic riding is enclosed for your information.
- A change in medical condition requires a physician referral update.

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**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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_



### 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 spondylolisthesis (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
- Spondylolisthesis (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, spondylolisthesis 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



### **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:

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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): \_\_\_\_\_

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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: \_\_\_\_\_