The Harold and Kay Peplau Therapeutic Riding Center
Home of Therapeutic Riding, Inc.
3425 E. Morgan Rd • Ann Arbor, MI 48108 | 734-677-0303 | rider@therapeuticridinginc.org

2018 | RIDER FORMS

Note: All active riders must return all forms in this packet by March 1, 2018. Please retain this cover sheet for your reference.

Form Checklist

Please review the checklist below before submitting your forms. This will ensure your forms are complete and ready for review. Hard copies must be mailed to or dropped off at the barn. We **do not accept** faxed, emailed, or scanned forms.

_____ **Form 1: Participant Application & Health History (2 pages)**

_____ **Form 2: Authorization for Emergency Medical Treatment**

_____ **Form 3: Photo Release, Confidentiality Policy & Liability Release**

_____ **Form 4: Medical History & Physician's Statement**
(Note: This form must be filled out by a medical professional)

Important Dates

Availability forms serve as your sign-up for each session you'd like to participate in. Active riders must submit availability forms indicating whether or not you are participating in the upcoming session. Failure to return paperwork may result in losing your active rider status. Please **make note** of all form and payment due dates. Forms will be made available on our website and sent to all active riders via e-mail prior to each due date.

*March 1, 2018—Annual Rider Forms Due

*Early Bird Session: February 5-March 17 (6 weeks)

January 8, 2018—Early Bird Availability Form & Payment Due ($180)

*Spring/Summer Session: April 9-July 28 (14 weeks)

March 1, 2018—Spring/Summer Availability & Payment Due ($420)

May 27-June 2, 2018—No classes, week of Memorial Day

July 1- 7, 2018—No classes, week of July 4th

*Fall Session: September 4-November 3 (8 weeks)

August 1, 2018—Fall Availability Form & Payment Due ($240)

September 18-22, 2018—No classes, week of Boots, Brews & BBQ Event

*Holiday Session: November 5-December 15 (5 weeks)

August 1, 2018—Holiday Availability Form & Payment Due ($150)

November 19-24, 2018—No classes, week of Thanksgiving

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2018 | Rider Form 1: Registration & Health History—*Page 1 of 2*

Participant's Name: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Address: _____ City/State/ZIP: _____

Primary Phone: _____ Alternate Phone: _____

Email Address: _____

Parent/Legal Guardian's Name: _____

Address (if different from above): _____

Primary Phone: _____

Please list names and contact information for any other caregivers who may transport or be responsible for the participant while he/she is at TRI: _____

_____

_____

Health History

Diagnosis/Disability: _____

Please indicate current or past problems in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

Please make sure your forms are **complete**. Hard copies must be mailed to or dropped off at the barn.
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Questions? Contact us! rider@therapeuticridinginc.org or call 734-677-0303

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

Describe your abilities/difficulties in the following areas (include assistance required or equipment 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)

What would you like to accomplish at TRI?

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2018 | Rider Form 2: Authorization for Emergency Medical Treatment

Participant's Name: _____

Date of Birth: _____ Primary Phone: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Diagnosis/Disability: _____

Allergies to Medications: _____

Current Medications: _____

_____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during while receiving services, or while being on the property of the agency, I authorize **Therapeutic Riding Inc.**, to:

1. Provide/retain emergency treatment and transportation if needed.
2. Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the attending physician. This provision will only be invoked if the person(s) above is unable to be reached.

Consent Signature: _____ Date: _____
(if over 18 and legally responsible)

Printed Name: _____

Consent Signature: _____ Date: _____
(parent/legal guardian if participant is under 18 or not legally responsible)

Printed Name: _____

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2018 | Rider Form 3: Photo Release, Confidentiality Policy, Emergency Authorization & Liability Release

1) Photo Release

Note: Participation in Therapeutic Riding Inc. as a volunteer is not contingent on an affirmative (yes) response on this "Parent/Guardian-Adult Volunteer Video, Film and Photography Release (Photo Release) Form."

I ☐ DO ☐ DO NOT

authorize **Therapeutic Riding Inc.** to record the image and voice of the subject named below and give Therapeutic Riding Inc. and all persons or entities acting pursuant to Therapeutic Riding Inc.'s permission or authority, all rights to use of these recorded images and voice. I understand that said images and/or voice will be used for educational, advertising and promotional purposes in all conventional and electronic media, including but not limited to the Internet, and any future media. I also authorize the use of any printed material in connection therewith. I understand and agree that these images and recordings may be duplicated, distributed with or without charge, and/or altered in any form or manner without future or further compensation or liability, in perpetuity.

_____ **(initial here, indicating you have read & fully understand the Photo Release)**

2) Confidentiality Policy

Therapeutic Riding, Inc. shall preserve the right of confidentiality for all individuals (volunteers, riders, and staff) in its program. As a rider, you must maintain the confidentiality of sensitive information regardless of how it is obtained. Information which must be kept confidential should include but, not be limited to: all medical, social, referral, personal, and financial information regarding a person and his/her family.

_____ **(initial here, indicating you have read, fully understand & agree with the Confidentiality Policy)**

3) Authorization for Emergency Medical Treatment

In the event emergency medical aid/treatment is required due to illness or injury while receiving services, or while being on the property of the agency, I authorize **Therapeutic Riding, Inc**. to provide/retain emergency treatment if needed.

_____ **(initial here, indicating you have read, fully understand & agree with the Authorization for Emergency Medical Treatment)**

4) Liability Release

I/we assume the risks and accept the consequences involved in the participation of:

(Participant's Name):_____

In the **Therapeutic Riding Inc.** program, 3425 E. Morgan Road, Ann Arbor, MI 48108. I/we acknowledge that horses may be dangerous because they may, without warning, buck, stumble, kick, or move in otherwise unpredictable ways. I/we are hereby informed of the risk of bodily injury to me/my child/my ward that may result from participation in the program, including injuries to the head, soft tissue (including skin and muscle), ligaments and tendons, bones and joints, and exacerbation of chronic conditions. I/we accept the responsibility for complying fully with all safety rules and practices and I/we will consult with the instructor and/or director of Therapeutic Riding Inc. for advice in circumstances where safe practices are in doubt. I/we hereby release Therapeutic Riding Inc., including their instructors, staff, Board of Directors, and volunteers, from any liability for injury that may result from participation in the program.

Warning: Under the Michigan Equine Activity Liability Act, an equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of the equine activity.

_____ **(initial here, indicating you have read, fully understand & agree with the Liability Release)**

I/WE HAVE READ, FULLY UNDERSTAND & AGREE WITH THE 1) PHOTO RELEASE, 2) CONFIDENTIALITY POLICY, 3) AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT, AND 4) LIABILITY RELEASE. ***I/WE UNDERSTAND THIS DOCUMENT IS VALID UNTIL I/WE REVOKE IT IN WRITING WITH THERAPEUTIC RIDING, INC.***

Signature: _____ Date: _____

(participant if over 18 and legally responsible—or—parent/legal guardian if participant is under 18 or not legally responsible)

Printed Name: _____

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2018 | Rider Form 4: Medical History & Physician's Statement

Participant's Name: _____

Note: The following sections must be filled out by a medical professional

Height: _____ Weight: _____ *(note: weight limit is 200lbs, dependent on balance, mobility & suitable horses)*

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Current Medications: _____

_____

Seizure Type: _____ Controlled: ___Y ___N Date of Last Seizure _____

Shunt Present: _____ Date of Last Revision: _____

Indwelling Catheters or Spinal Rods Present: ___Y ___N Location: _____

Mobility: Independent ___Y ___N Assisted ___Y ___N Wheelchair ___Y ___N

Braces/Assistve Devices: _____

Required for those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result: ___+ ___-

Are there any neurological symptoms of AtlantoAxial Instability? _____

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Y	N	Comments
Vision			
Hearing			
Speech			
Neuro-Sensation			
Muscular			
Balance/Coordination			
Pulmonary/Cardiac			
Orthopedic			
Cognitive/Learning			
Emotional/Psychological			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that **Therapeutic Riding Inc.** will weigh the medical information above against the existing precautions and contraindications.

Printed Name & Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____

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