Therapeutic Riding CENTER South Jersey

Application Forms: Therapeutic Riding CENTER South Jersey (The Center) provides all the necessary forms. Forms must be completed, dated and signed by all appropriate parties prior to participation. Please note, a physician must sign the Medical History form. Once completed, please return the forms to: Terrance P. Lewis/Therapeutic Riding CENTER South Jersey, 322 Route 537 Colts Neck, NJ 07722.

Once the forms have been received, prospective participants will be contacted for a pre-riding assessment conducted by staff.

The information you provide on the enclosed forms and the assessment will assist us with:

1. Determining the appropriateness of the program for the participant;
2. Scheduling; and
3. Goals for the student

Scheduling: Sessions are open ended with goals and objectives reviewed every eight weeks. Lessons are weekly and for 30 minutes each. Lessons are scheduled for the same day and time each week.

Cost in 2013: Thirty minute lessons are $35.00 each. Lessons are payable monthly in advance on the first Tuesday of the month.

Attendance: We understand that absences from lessons are sometimes unavoidable. Experience has shown us that riders who consistently attend their lessons show greater improvement in the area of physical stamina, balance, posture and coordination. If you are unable to attend a regularly scheduled lesson, notification must be made by calling 1.732.261.6441 as soon as the absence is anticipated so that we may provide sufficient notice to staff and volunteers. Full payment will be charged for students who do not show up for a lesson

Timeliness: Lessons that start late result in a loss of valuable riding time. We are unable to extend the lesson beyond the regularly scheduled end time. Please be on time for your lesson.

Attire: We will provide riding helmets, which are mandatory when riding or driving. Should you have your own helmet, it must be ASTM-SEI approved. Participants should dress weather appropriate and always wear long, non-slip pants even during the summer. Jackets and gloves are required for cold weather, as the indoor arena is not heated. Sturdy-soled boots or shoes are required. No clogs, sandles or flip-flops.

Mailing address: T. Lewis/ TR CENTER SJ, 322 Route 537, Colts Neck, NJ 07722

Physical address: Gloucester Co. DREAM Park, 400 RT 130, Logan Township, NJ 08085

THERAPEUTIC RIDING CENTER SOUTH JERSEY

Facility Safety Policy

1. Safety is our highest priority. Please observe our policies and posted signs. Authorized personnel only on mounting blocks and ramps.

2. Confidentiality is also very important. Any information regarding students, volunteers, staff, visitors and horses is strictly confidential and not to be disseminated.

3. Photography / video is not permitted without prior permission from staff.

4. All riders must be dressed appropriately for safe riding. An ASTM-SEI approved riding helmet, properly fitted and secured, is mandatory when riding or driving. Long pants are required with shirts / jackets tucked in or zippered. Long hair must be tied back and no dangling jewelry is allowed. No clogs, sandles or flip-flops to be worn by anyone around the horses.

5. Either a parent or instructor must accompany students at all times.

6. Parents, legal guardians or caregivers must remain on the premises during lessons if the participant is under the age of 14 or if the participant is in the care of a parent, legal guardian or caregiver. No student drop-offs are permitted.

7. A parent or other responsible adult must accompany, and supervise, children under the age of 14 at all times.

8. Eating and drinking while riding or driving is not permitted. This includes chewing gum!!

9. Please refrain from offering food to students without permission as they may have a medical condition such as food allergies, diabetes, etc.

10. Any conflicts should be handled immediately between parties involved and staff. Please contact the Program Director if the concerns are not being addressed or resolved.

11. The speed limit on "The Center" is 5 mph. Please park within the designated area only and ensure car alarms are off.

12. Smoking, alcohol or illegal substances are not permitted anywhere on the property.

13. For the safety of all, please be sure your cell phones are on "vibrate". Unexpected noises may startle the horses.

14. No pets are permitted anywhere on the premises.

15. Behave calmly around horses. No running and use soft voices.

16. Please do not feed the horses as hand feeding encourages biting. It is important for the horse's health that we monitor what they eat. Horse treats may be left with the staff and will be distributed when appropriate.

17. Remember to clean up after yourself. This helps to keep the premises safe, neat and clean.

Therapeutic Riding CENTER South Jersey

Participant's Application & Health History

(To be completed by Student/ Parent/ Legal Guardian)

General Information

Participant: ______________________________

DOB: ____________ Age: ______ Height: ______ Weight: ______ Gender: M F

Address: ______________________________ NJ ______
Street Town Zip

Phone: (H) ____________________ (C): ____________________

E-mail: ______________________________

Employer/School: ______________________________

Address: ______________________________

Phone: ______________________________

Parent/Legal Guardian: ______________________________

Address (if different from above): ______________________________

Phone: (H) ____________________ (C) ____________________

How did you hear about the program? ______________________________

Health History

Diagnosis: ______________________________ Date of Onset: ____________

Please indicate current or past special needs in the following areas:

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

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Participant's Application & Health History

(To be completed by Student/ Parent/ Legal Guardian)

Medications (include prescription, over-the-counter; name, dose and frequency) ______________

____

____

____

____

Allergies to over-the-counter drugs (aspirin, Benadryl etc) ______________________

____

____

Physical Function (e.g. mobility skills such as transfers, walking, wheelchair use)

____

____

____

Psychosocial Function: (e.g. work/school including grade completed, leisure interests, relationships, family structure, support systems, companion animals, fear/concerns etc.)

____

____

____

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

____

____

____

____

Signature: ________________________________ Date: ______________________

Participant/Parent/Legal Guardian

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Therapeutic Riding CENTER South Jersey

Date: ______________________

Dear Health Care Provider:

Your patient, ______________________________________
(participant's name)
is interested in participating in supervised horseback riding and equine activities. In order to safely provide this service, our center requests that you complete/ update the attached Medical History and Physician's Statement. 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
Coxarthrosis
Cranial Defects
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
(i.e. 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 horseback riding and equine-assisted activities, please feel free to contact me.

Sincerely,

Terrance (Terry) P. Lewis

Head Instructor/ Program Director

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Therapeutic Riding CENTER South Jersey

Participant's Medical History & Physician's Statement

(To be completed by Physician)

Participant: ______________________________

DOB: __________ Age: ______ Height: ______ Weight: ______ Gender: M F

Address: ______________________________

Diagnosis: ______________________ Date of Onset: __________

Past/Prospective Surgeries: ______________________________

Medications: ______________________________

Allergies to 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: ______________________________

Neurologic Symptoms of Atlantoaxial Instability: ☐ Present / ☐ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	Y	N	Comments
Allergies			
Auditory			
Balance			
Cardiac			
Circulatory			
Cognitive			
Emotional/Psychological			
Immunity			
Integumentary/Skin			
Learning disability			
Muscular			
Neurologic			
Orthopedic			
Pain			
Pulmonary			
Speech			
Tactile sensation			
Visual			
Other			

Given the above diagnosis and medical information, this person is **not** medically precluded from participation in horseback riding and equine-assisted activities and/or therapies. I understand that the PATH INTL. center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH INTL. center for ongoing evaluation to determine eligibility for participation.

Name/Title: ______________________ MD DO NP PA Other __________

Signature: ______________________ Date: ______________________

Address: ______________________________

Phone: ______________________ License/UPIN Number: __________

Therapeutic Riding CENTER South Jersey

Confidentiality Statement

Name:____

Parent/ Legal Guardian:____

Individuals have a right to privacy that gives them control over the dissemination of their medical, financial, personal and other sensitive information. Therapeutic Riding CENTER South Jersey ("The Center") will preserve the right of confidentiality for all individuals at its center.

Trustees, full- and part-time staff, independent contractors, temporary employees, volunteers, participants, parents, guardians, and families, or any business providing service to The Center are bound to keep confidential all medical, social, referral, personal and financial information, obtained either accidentally or on purpose whether in person or electronically, regarding any individual and his/ her family at The Center without the specific written consent of that individual or his/ her parent or guardian.

Signature: (Participant/Parent/Guardian)_________________________________ Date:_____________

PHOTO RELEASE

I ______ DO

______ DO NOT

consent to and authorize the use and reproduction by Therapeutic Riding CENTER South Jersey of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities and exhibitions or for any other use for the benefit of the program.

Signature:
(Participant/Parent/Guardian)___________________________________Date:____________________

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THERAPEUTIC RIDING CENTER SOUTH JERSEY

Liability Release Form

Name:____

Parent/Legal Guardian:________________________________

UNDER NEW JERSEY LAW, AN EQUINE EQUESTRIAN AREA OPERATOR IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ANIMAL ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ANIMAL ACTIVITIES, PURSUANT PL, C287c. 5:15 to 5:151-12.

I understand that under the New Jersey Equine Activity Liability Act, each participant who engages in equine activities, including, but not limited to:

1. The propensity of equines to behave in dangerous ways that may result in injury to the participant,
2. the inability to predict an equine's reaction to sounds, movements, objects, persons, or animals,
3. the hazards of surface or subsurface conditions and
4. the hazards relating to the use of the premises and relating to any animals, facilities or equipment owned or leased or used by Therapeutic Riding Center South Jersey (The Center).

PLEASE NOTE: It is the policy of The Center that 9-1-1 be called in the event of an emergency.

I have been advised that I must wear an ASTM-SEI approved helmet at all times when riding or driving horses.

I hereby, intending to be legally bound, for myself, my heirs and assigns, executors and/or administrators, waive and release forever all claims for damages against Therapeutic Riding Center South Jersey, either of it's members, board of trustees, officers, staff, instructors, therapists, aides, volunteers for any and all injuries and/or losses that I/my son/my daughter/ my ward may sustain while participating in activities at the center.

This release shall remain valid until expressly revoked in writing by a participant, or if a minor, the parent or guardian.

I have read and understand the provided information and agree with the terms in their entirety.

Signature:______________________ Date:______________________

In the event of an emergency please contact:

Name:______________________________ Relationship:______________________________

Phone: (H)____________________________ (C) ____________________________________

Name:______________________________ Relation: _________________________________

Phone (H)_____________________________ (C) ____________________________________