Bridge Riding for The Disabled
743 West Pekin Road
Lebanon, OH 45036
1-937-654-4693
howe.pm@earthlink.net

Participant's Health History

To be completed by the participant or parent/legal guardian

GENERAL INFORMATION

Participant: ______________________________

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

Parent/Legal Guardian: ______________________________

Address: ______________________________

Phone: ____________________ Alternative #: ____________________

Referral Source: ______________________________

Phone: ______________________________

How did you hear about the program? ______________________________

Please describe details of following area that would aid riding instructors (for example; supervision needed, learning style, frustration levels, communication skills/challenges, ability to follow directions, behavior challenges)

____
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____
____
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____

HEALTH HISTORY

Diagnosis ______________________________ Date of Onset: ____________________

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

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

(over)

MEDICATIONS *(include prescription, over-the-counter; name, dose and frequency)* ____________________

____

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____

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

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

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PSYCHO/SOCIAL FUNCTION (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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PHOTO RELEASE

I ❑ DO
❑ DO NOT
consent to and authorize the use and reproduction by Bridge Riding for the Disabled of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: ____ Date: ____________________

Client, Parent or Legal Guardian
Signed in the presence of center staff

BRIDGE RIDING FOR THE DISABLED INC.,
CUTLER RIDGE STABLE
743 WEST PEKIN ROAD
LEBANON, OHIO 45036
(937) 654-4693

RIDING INSTRUCTION AGREEMENT AND LIABILITY RELEASE

READ CAREFULLY BEFORE SIGNING
SERIOUS INJURY MAY RESULT FROM YOUR PARTICIPATION IN THIS ACTIVITY. THE STABLE DOES NOT GUARANTEE YOUR SAFETY.

A. "Equine" means a horse, pony, mule or donkey. "Equine activity" means an activity involving a horse or other Equine, including horseback riding, training, teaching, testing or evaluating, trailering, lodging, transporting, holding, leading, grooming, petting, tacking, side helping or assisting a rider and all activities covered by Section 2305.321 of the Ohio Revised Code.

B. **REGISTRATION OF RIDERS AND AGREEMENT PURPOSE** In consideration of Bridge Riding for the Disabled Inc., Patricia Howe (whether acting as an individual, sole proprietor or otherwise) and Cutler Ridge Stable (collectively referred to as the "Stable") allowing my participation in horseback riding or other Equine activity, under the terms set forth herein, I, the following listed individual, and the parent or legal guardians thereof if a minor, do hereby voluntarily request to participate in riding instruction and/or other Equine activity at the Stable and that this student will either ride his/her own horse, or school horses provided by the Stable for instructional purpose, today and on all future dates:

RIDER NAME	AGE (If under 21)	WEIGHT Over 180#	HORSE RIDING EXPERIENCE (Check one which applies)
1.	________	____YES ____NO	____BEGINNER (under 10 hours) ____ OVER 10 HOURS
Does this rider have any physical and/or mental health conditions, problems, disorders, and/or disabilities with special needs which may affect his/her safety and ability to ride a horse? **Yes** **No** If "yes" describe here and advise the Stable prior to riding of how we may assist you with any special needs:			

C. **ACTIVITY RISK CLASSIFICATION** - - I UNDERSTAND THAT: Horseback riding and other Equine activity is classified as RUGGED ADVENTURE RECREATIONAL SPORT ACTIVITY, and that there are numerous obvious and non-obvious inherent risks always present in such activity despite all safety precautions. According the NEISS (National Electronic Inquiry Surveillance Systems of United States Consumer Products) horse activities rank approximately 64th among the activities of people relative to injuries that result in a stay at U.S. hospitals. Related injuries can be severe requiring more hospital days and resulting in more lasting residual effects than injuries in other activities.

Further, pursuant to the Ohio Equine Activity Statute (Ohio Revised Code Section 2305.321), I hereby acknowledge the following inherent risk of an equine activity:

"Inherent risk of an equine activity" means a danger or condition that is an integral part of an Equine activity, including, but not limited to, any of the following:

a) the propensity of an equine to behave in ways that may result in injury, death, or loss to persons on or around the equine;

b) the unpredictability of an equine's reaction to sounds, sudden movement, unfamiliar objects, persons , or other animals;

c) hazards, including, but not limited to, surface or subsurface conditions;

d) a collision with another equine, another animal, a person, or an object; and,

e) the potential of an equine activity participant to act in a negligent manner that may contribute to injury, death, or loss to the person of the participant or to other persons, including, but not limited to, failing to maintain control over an equine or failing to act within the ability of the participant.

D. **SADDLE GIRTHS/NATURAL LOOSENING** - - I UNDERSTAND THAT: Saddle girths (saddle fasteners around horse's belly) may loosen during a ride. If a rider notices this he/she must alert the riding instructor immediately so action can be taken to avoid slippage of saddle and a potential fall from the animal.

E. **PROTECTIVE HEADGEAR WARNING** - - I AGREE THAT: I have been fully warned and advised by the Stable that I should purchase and wear protective headgear of a quality not less than an SEI CERTIFIED ASTM STANDARD F 1163 Equestrian Riding Helmet while riding, being and working around horses. I do understand that the wearing of such headgear while mounting, riding, dismounting, and otherwise being around horses, may prevent or reduce severity of some of the headgear wearer's head injuries and may even prevent the wearer's death from happening as the result of a fall from a horse or other occurrence.

F. **NATURE OF THE STABLE'S SCHOOL HORSES** - - I UNDERSTAND THAT: The Stable chooses the school horses based on its perception of their calm dispositions and sound basic training as is appropriate for use for STUDENT RIDERS, and the Stable follows a rigid safety program. Yet, no riding horse is a completely safe horse. Horses are 5 to 15 times larger, 20 to 40 times more powerful, and 3 to 4 times faster than a human. If a rider falls from horse to ground it will generally be at a distance of from 3 ½ to 5 ½ feet, and the impact may result in injury to the rider.

G. **RIDER RESPONSIBILITY** - - I UNDERSTAND THAT: Upon mounting a horse and taking up the reins the rider is in primary control of the horse. The rider's safety largely depends upon his/her ability to carry out instructions, and his/her ability to remain balanced aboard the moving animal. I agree that the rider is and shall be responsible for his/her own safety, including that of her unborn child, if the rider is pregnant. Pregnant women should ride horses only under the advice of their physician. the Stable advises pregnant women not to ride horses.

H. **CONDITIONS OF NATURE AND INSPECTION OF PREMISES** - - I UNDERSTAND THAT: The Stable is NOT responsible for total or partial acts, occurrences, or elements of nature or provocation that can scare a horse, cause it to fail, or react in some other unsafe way which may include, but is not limited to: Stopping short; Changing directions or speed at will; Shifting its weight; Bucking, Rearing, Kicking, Biting or Running from danger. SOME EXAMPLES ARE: Thunder, lightening, rain, wind, wild and domestic animals, insects, reptiles, which may walk, run, or fly near, or bite or sting a horse or person; and irregular footing on out-of-door groomed or wild land which is subject to constant change in condition according to weather, temperature, and natural and man-made changes in landscape. The rider and parent or legal guardian have inspected (or had the opportunity to inspect) the Stable's facilities and are satisfied that all premise conditions are reasonably safe for rider's intended purpose, usage and presence.

I. **ACCIDENT/MEDICAL INSURANCE** - - I AGREE THAT: Should emergency medical treatment be required, I and/or my own accident/medical insurance company shall pay for all such expenses incurred in connection therewith by such insurance company and/or me, my family, spouse, heirs, legatees, divisees and estate.

J. **LIABILITY RELEASE ASSUMPTION OF RISK - - I AGREE THAT: In consideration of the Stable allowing my participation in horseback riding and/or other Equine activity, under the terms set forth herein, I, the rider, and the parent or guardian thereof if a minor, do (a) agree to hold harmless and release the Stable, its owners, agents, volunteers, employees, officers, members, premises owners, affiliated organizations, and Insurers from legal liability due to any of their negligence or to the negligence or actions of its riders or customers, (b) waive any legal claim I or my minor child or ward named above may have against the Stable, its owners, agents, volunteers, employees, officers, members, premises owners, affiliated organizations, and Insurers for injuries resulting from an inherent risk of an equine activity, including (but not limited to) those specified above and (c) agree that I am participating in all Equine activities at the Stable at my own risk and assume all risk of damage or injury to my person or property other than that due to the intentional misconduct of the Stable. I understand that this waiver will remain effective unless and until revoked by me in writing.**

K. This agreement is governed by Ohio law regardless of the place of my residence. The courts of Ohio shall have exclusive jurisdiction over all matters related to this agreement.

SIGNER STATEMENT OF AWARENESS

I/WE, THE UNDERSIGNED, HAVE READ AND HAD AN OPPORTUNITY TO ASK QUESTIONS REGARDING THIS AGREEMENT AND THE STABLE. I DO UNDERSTAND THE FOREGOING AGREEMENT, WARNINGS, RELEASE AND ASSUMPTION OF RISK. I/WE FURTHER ATTEST THAT ALL FACTS RELATING TO THE APPLICANT'S PHYSICAL CONDITION, EXPERIENCE, & AGE ARE TRUE AND ACCURATE.

____ ________________________________ DATE___________
SIGNATURE OF RIDER (Spouses must sign for themselves.) NAME (Please Print)

____ for ________________________________ DATE___________
SIGNATURE OF PARENT, GUARDIAN AND/OR SPOUSE # 1 NAME (Please Print)

____ for ________________________________ DATE___________
SIGNATURE OF PARENT, GUARDIAN AND/OR SPOUSE # 2 NAME (Please Print)

Address in full:____________________________________ Home Phone #:__________________________

____________________________________ Bus. Phone #:__________________________

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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 property of the agency, I authorize Bridge Riding for the Disabled to:

1. Secure and retain medical treatment and transportation if needed.
2. Release records upon request to the authorized individual agency involved in the medicaI emergency treatment.

Name:____Phone: __________________________

Address:____

In the event I cannot be reached;

Contact:____Phone:__________________________

Contact:____Phone:__________________________

Physician's Name:____Phone:__________________________

Preferred Medical Facility:____

Health Insurance Co.:____Policy#:_________________________

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 listed below is unable to be reached.

Date:______________Consent Signature:,____
(If under 2l yrs.. parent or guardian)

Print Name:____Phone:_________________________

Address:____

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in the case of illness of injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment is required, I wish the following procedures to take place:____

____

Date:__________________Non-consent Signature:,____

Print Name:____Phone:_________________________

Bridge Riding for the Disabled

Rider's Medical History and Physician's Statement

(to be completed annually)

Name:____Date of Birth________________________

Address:____

Parent/Guardian: ____

Diagnosis:____Date of Onset_______________________

**For persons with Down Syndrome:*

Cervical X-ray for Atlantoaxial Instability: Positive________ Negative________ X-ray Date: ________________

Tetanus Shot ❒ Yes ❒ No Date:_________ Height ________ Weight: ________

Seizure Type: ____________________ Controlled: _________________ Date of Last Seizure______________

Medications: ____

Please indicate if patient has a problem and or surgeries in any of the following areas by checking yes or no.
If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation Yes ❒ No❒ Crutches Yes ❒ No❒ Braces Yes ❒ No❒ Wheelchair Yes ❒ No❒

Please indicate any special precautions:____

____

____

____

____

Information for Physician

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial lnstabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis imperfecta
Cranial Deficits
Spinal Orthosis
Internal Spinal Stabilization Devices

Neurologic

Hydoroephalus/shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis due to Spinal Cord injury
Seizure Disorders

Medical/Surgical

Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident)

Secondary Concerns

Behavior problems
Age under two years
Age two - four years
Acute exacerbation of chronic disorder
lndwelling catheter

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician Name (please print) ____________________________ Physician Signature__________________________

Address____ City __________________ State_____ Zip _________

Phone(____) _______________________ Date:__________________

Please Return To:

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