*4705 Winkler Road*Philpot, KY 42366*
(270) 883-1418

2020 Participant Package Check List

All of the forms listed below are required to be completed, checked, signed and dated as indicated prior to the start of rider participation and annually thereafter.

To be completed by participant, parent or caregiver by

- ☐ 1.Participant package check list
- ☐ 2.Participant registration form
- ☐ 3. Contact and tuition payment
- ☐ 4. Participant Release
- ☐ a) Liability release
- ☐ b) Confidentiality agreement
- ☐ c) Photo and video release
- ☐ 5. Annual Health History and Contact Information Update Form
- ☐ 6. Possible reasons for discharge form
- ☐ 7. Participant goal sheet
- ☐ Payment, check ☐ or Cash ☐

To be completed by the participant's physician

- ☐ 8. Information for Physician (Precautions and Contraindications)
- ☐ 9. Rider health history/physician assessment form
- ☐ b) Neurological exam results for Atlanto-axial Instability for persons with Down Syndrome (if applicable)
- ☐ 10. Physician release

Optional Information if applicable to the participant's goals/needs

- ☐ 11. Physical/Occupational/Speech Therapy Forms
- ☐ 12. I.E.P. Individual Education Plan

For office use only

Forms	1	2	3	4	5	6	7	8	9	10	11	12

Dream Riders of Kentucky Participant Registration

*4705 Winkler Road*Philpot, KY 42366*
(270) 883-1418

Program Information Date_____

Participant Name: _____ Phone: _____

DOB_____ Age_____ Height_____ Weight_____ Gender M F

Primary Diagnosis_____

Secondary Diagnosis_____

Mobility status (walks unassisted, assistive devices, etc.) _____

Address_____

Communication (verbal, non-verbal signs) _____

Behaviors (impulsive, fearful, frustration tolerance) _____

_____

Medications Taken_____

Seizures (if applicable please describe) _____

Limitations_____

Alergies_____

Skin sensitivity_____

Participant's occupation/ school grade level_____

Affiliate Program if applicable_____

Personal Goals (fill in the areas that apply) _____

Physical_____

Cognitive_____

Social/Behavioral_____

Emotional _____

Life skills_____

Availability for the DREAM RIDERS OF KENTUCKY, INC. Program (Check all available times and days)

[ ] Tuesday am	[ ] Tuesday afternoon	[ ] Tuesday evening
[ ] Wednesday am	[ ] Wednesday afternoon	[ ] Wednesday evening
[ ] Thursday am	[ ] Thursday afternoon	[ ] Thursday evening

For staff use only:

Start Date_____ Confirmed Day: _____ Time: _____

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2020 Dream Riders Participant Contact and Tuition Information

Participant Name: _____

Address_____

City/State/Zip_____

Home Phone_____ Cell_____

Email Address_____

Names of parents/guardian:

Father_____ Cell_____ Email_____

Mother_____ Cell_____ Email_____

Best Emergency Contact: Name_____

Phone_____ Cell_____

Parent occupation and employer:

Father_____ Work Phone_____

Mother_____ Work Phone_____

How were you referred to ***DREAM RIDERS OF KENTUCKY, INC.?*** _____

2020 Program Tuition Payment Details

Please tell us how you will be paying:

- ○ Check (please make payable to Dream Riders of Kentucky)
- ○ Debit or credit

I understand and agree that all paperwork must be up to date in the calendar year in which I am participating. All tuition is to be paid prior to the start of each semester. The rate for each semester is $150. If applicable, all scholarship forms must accompany the rider application. Scholarships are available for those who qualify, please contact the Executive Director for further information. In no way does Dream Riders of Kentucky Inc. want to turn anyone away due to financial constraints.

Signature of Participant or Legal Guardian_____ Date_____

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Participant Liability Release, Confidentiality Agreement, Photo and Video Release

Participant Name: _____ Date: _____

Parent/Legal Guardian/ Conservator (if applicable) _____

Liability Release:
Name of Parent/Gaurdian/Conservator_____
I acknowledge the risks and potential risks for horseback riding and activities in and around a facility where horses are kept, and farm machinery operated. However, I feel that the possible benefits to me/my son/my daughter/my ward are greater than the risk assumed. Intending legally to bind myself, my heirs, and assigns, executors or administrators, I hereby waive and release forever all claims for loss or damages of any kind against ***DREAM RIDERS OF KENTUCKY, INC***., its Board of Directors, Instructors, Therapists, aids, Volunteers and employees for any and all injuries and losses that I/my son/my daughter/my ward may sustain while participating in the DREAM ***RIDERS OF KENTUCKY, INC.*** program. This release includes without limitation the risk of negligent instruction and supervision. I engage in activities at ***DREAM RIDERS OF KENTUCKY, INC.*** voluntarily with knowledge of the risks and I assume all risks of injury, death, and property damage that may result. I agree to bear any loss myself. I acknowledge that ***DREAM RIDERS OF KENTUCKY,*** INC. and the property owners are materially relying on this waiver and assumption of risk in allowing me/my son/my daughter/my ward to participate in activities at ***DREAM RIDERS OF KENTUCKY, INC.***

Date_____ Signature_____
(Participant, Parent or Caregiver)

Confidentiality Agreement:
I understand that all the personal information (written and verbal) about participants at ***DREAM RIDERS OF KENTUCKY, INC***. is confidential and not to be shared with anyone without expressed written consent of the participant and their parent/guardian in the case of a minor.

Date_____ Signature_____
(Participant, Parent or Caregiver)

Photo and Video Release:

- ☐ I consent to and authorize
- ☐ I do not consent to nor do I authorize

The use and reproduction by ***DREAM RIDERS OF KENTUCKY, INC.*** of any other audio/visual materials taken of me/my son/my daughter/my ward for distribution to the public for promotional printed materials, educational activities or for any other use for the benefit of the program.

Date_____ Signature_____
(Participant, Parent or Caregiver

2020 Dream Riders of Kentucky
Annual Health History and Contact Information Update Form

Date: _____

Name of Participant: _____

Name of Parents/Guardian (if applicable): _____

Address: _____City: _____Zip: _____

Home Phone_____ Cell: _____

E-mail: (Please print clearly and carefully) _____

Participant DOB: _____Sex: _____ Height: _____Weight: _____

Diagnosis + changes_____

Emergency Contact Name: _____

Phone: _____Relationship: _____

Preferred Medical Facility: _____Physicians Name: _____

Health Insurance Company: _____Policy # _____

Current Medications: _____

Allergies: _____

Precautions/Restrictions: _____

Please explain any recent changes in health or behavior status:

_____

_____

_____

_____

Signature: _____ Date: _____

Print Name and Relationship: _____

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2020 Possible Reasons for Participant Discharge

Please be advised of the following reasons that may lead to discharge from the riding program.

1. The client has reached all of their goals and is ready to graduate.
2. The client's potential to maintain head and neck control while riding presents a safety concern.
3. Inability to follow directions is interfering with progress toward goals.
4. Uncontrolled and/or inappropriate behavior that constitutes a safety risk to client, staff and/or horse.
5. Client exceeds weight that can safely be managed by staff, volunteers, and/or horses.
6. Any change in the client's medical, physical, cognitive, or emotional condition that makes therapeutic riding inappropriate.
7. Three scheduled appointments are missed without prior cancelation.
8. Non-payment of fees as originally agreed.

I understand and agree with the possible reasons for client discharge.

Signature of Participant or Legal Guardian: _____

Date: _____

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2020 Participant Goals

Please help us help you get the most out of your classes by filling out the following goal setting sheet.
Thank you.

Participant name: _____
Parent name: _____
Email address: _____
Class day/time: _____

All goals are reflective of the next term. The categories are meant as a guideline and all categories may not apply to all students.

Personal riding goals: _____
_____
_____
_____

Physical goals: _____
_____
_____
_____

Cognitive goals: _____
_____
_____
_____

Social goals: _____
_____
_____
_____

Long-term goal over the next year.

Goals Dated: _____
_____
_____

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2020 Information for Physician

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding**. Please complete the Dream Riders of Kentucky, Inc. Medical Release and Health History Assessment forms. Also, please note if any of the following conditions are present, and to what degree.**

Orthopedic	Medical/Surgical
Spinal Fusion	Allergies
Spinal Instabilities/Abnormalities	Cancer
Atlantoaxial Instabilities	Poor Endurance
Scoliosis	Recent Surgery
Kyphosis	Diabetes
Lordosis	Peripheral Vascular Disease
Hip Subluxation and Dislocation	Varicose Veins
Osteoporosis	Hemophilia
Pathological Fractures	Hypertension
Coxas Arthrosis	Serious Heart Condition
Heterotopic Ossification	Stroke (Cerebrovascular Accident)
Cranial Deficits	
Spinal Orthoses	
Internal Spinal Stabilization Devices	

Neurological	Secondary Concerns
Hydrocephalus/shunt	Behavior Problems
Spina Bifida	Age under Two Years
Tethered Cord	Age Two - Four Years
Chiari II Malformation	Indwelling Catheter
Hydromyelia	Acute Exacerbation of Chronic Disorder
Paralysis due to Spinal Cord Injury	
Seizure Disorders	

(Please give to the participant's physical as a guideline for Therapeutic Riding)

2020 Annual Participant Health History

Participant Name_____ DOB_____ Height_____ Weight_____

Address_____

Diagnosis: _____ Date of Onset_____

Past/Prospective Surgeries: _____

Medications_____

Seizures Y N Type_____ Controlled Y N Date of Last Seizure_____

Shunts/Implants/Appliances _____

Hospitalizations/Surgery_____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Neurologic Symptoms of Atlanto Axial Instability Yes No _____

Please indicate and comment on any Special Problem Areas Below:

Area	**Yes**	**No**	**Comments**
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological/Sensation			
Bowel/Bladder			
Muscular			
Orthopedic			
Allergies			
Behavior			
Cognition			
Emotional/Psychological			
Other			

2020 DREAM RIDERS of KENTUCKY

Physician Release

Participant name: _____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that ***DREAM RIDERS OF KENTUCKY, INC.*** will weigh the medical information contained in the physician release form against existing PATH Intl. precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional) e.g. PT, OT, Therapist, Psychologist, etc.) In the implementing of an effective equestrian program.

Physician's Signature:_____ Date:_____

Physician's name, address, and telephone number: (please print, type or stamp):

Physician Annual Medical Clearance report for Neurologic Symptoms of Atlanto Axial Instability Exam.

For All Participants with Down syndrome:

_____ has undergone a neurological exam by a licensed physician to test for symptoms consistent with atlantoaxial instability. _____ has been given medical clearance by the licensed physician below, due to the results of the neurological exam that denies any symptoms consistent with atlantoaxial instability.

Physician name: _____
Signature: _____
Stamp:
