RISING HOPE THERAPEUTIC RIDING CENTER

PARTICIPANT REGISTRATION FORM

First Name: ______________________________ Last Name: ______________________________

Gender: ☐ Male ☐ Female DOB: ________________________ Age: ____________________

Address: ____

City: __________________________ State: ______________________ Zip: _________________

Home #: _________________________________ Cell #: _________________________________

Work #: _______________________ Occupation/School: _________________________________

Parent/Guardian: ____

Phone #: _________________________ Email Address: _________________________________

PHOTO AND VIDEO RELEASE

☐ ***I CONSENT*** *(please check one)*

☐ ***I DO NOT CONSENT*** *(please check one)*

to and authorize the use and reproduction by Rising Hope Therapeutic Riding Center, Inc. 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 of Participant: ______________________________________ Date: ________________

Participant Authorization for Emergency Medical Treatment Medical Consent Plan

Participant Full Name: ____

Date of Birth: ____________________ Phone #: ____________________________

Address: ____

Physicians Name: ____

Preferred Medical Facility: ____

Health Insurance Co: _________________________ Policy #: ________________

Allergies to Medication: ____

Current Medication(s): ____

Additional Emergency Medical Information for Treating Medical Professional:

____

____

1. Emergency Contact Name: ____

Phone #: ___________________________ Relation: _______________________

2. Emergency Contact Name: ____

Phone #: ___________________________ Relation: _______________________

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 premises operated by *Rising Hope TRC, Inc.*,

I authorize *Rising Hope Therapeutic Riding Center, Inc.* **to:**

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

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 below is unable to be reached.

Signature: _______________________________________ Date: ____________

Consent Signature of Volunteer or Parent/Guardian

Participant Authorization for Emergency Medical Treatment Medical NON-Consent Plan

Participant Full Name: ____

☐ A parent or legal guardian will remain on site at all times during equine assisted activities.

☐ In the event emergency treatment/aid is required, I wish the following procedures to take place:

____

____

I DO NOT give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency.

Signature: ______________________________ Date: ______________

NON-Consent Signature of Volunteer or Parent/Guardian

RISING HOPE WAIVER AND RELEASE

All Visitors, Participants, Volunteers (or Parent or guardian if under 21) **MUST SIGN THIS RELEASE WAIVING LEGAL RIGHTS AGAINST RISING HOPE THERAPEUTIC RIDING CENTER AND CYNTHIA LAMEY.** If you do not sign this release, you will not be permitted on the properties.

I, ____, a visitor to /participant of/volunteer in/the Rising Hope Therapeutic Riding Center equine assistance program (the "Program") or the parent or legal guardian of a visitor to /participant of/volunteer in/ the Program, am aware that all activities involving horses, including but not limited to riding, driving, grooming, leading, and/or any events involving horses, pose many inherent dangers, risks, and hazards. These include, but are not limited to, bodily injury and physical harm to riders, instructors, therapist, aides, groomers, leaders, handlers, side walkers, photographers, spectators and /or any other helpers. I freely and fully assume all dangers, risks, and hazards and the possibility of injury, death, property damage or other loss resulting from such dangers, risks, and hazards. I understand that I or my child or ward should not participate in the Program or visit the properties unless medically able. I agree to comply with Program rules and regulations, directions, instructions, and/or safety precautions given by Program employees, instructors, therapists, aides, and volunteers. My or my child's or ward's participation in the Program or visit to the properties is upon the express agreement and understanding that I have received, read, and understand the Waiver and Release.

In consideration of me or my child or ward's participation/volunteering in the Program or visit to the properties, I hereby, for myself and any participant for whom I am a parent or legal guardian release, discharge, hold harmless, and forever acquit Rising Hope Therapeutic Riding Center together with its officers, directors, agents, representatives, employees, instructors, therapists, aides, and volunteers, and Cynthia Lamey, in her individual capacity, and groom any and all actions, causes of action, losses, claims, or any liabilities whatsoever including but not limited to illness or injury known or unknown now existing or which may arise in the future, which may accrue to me, my heirs, my guardians, administrators, executors, or assignees, including attorney's fees and court costs, on account of or in any way related to or arising out my or my child or ward's participation in the Program or visit to the properties. Finally, assume all liability of any non-participants who accompany me.

I have had the opportunity to ask any questions that I may have and such questions have been answered to my satisfaction. I have read, understood and agree to the above. I understand and confirm that by signing this Waiver and Release that I have given up considerable future legal rights. My signature is proof of my intention to execute a complete and unconditional Waiver and Release of all liability to the full extent of the law.

Name (print): ____
Participant/Volunteer/Visitor's Signature

Signature: ______________________________________ Date: ______________
Participant/Volunteer/Visitor's Signature

AGREEMENT AND CONSENT OF PARENT OR GUARDIAN OF MINOR

I, as the parent of guardian of the above visitor or participant, give my permission for my child or ward to participate in the Program or visit the properties. And further, in consideration of allowing my child or ward to participate in the Program or visit the property, I agree individually and on behalf of my child or ward to the terms of the above Waiver and Release.

Name (print): ____
Participant/Volunteer/Visitor's Signature

Signature: ______________________________________ Date: ______________
Participant/Volunteer/Visitor's Signature

PAYMENT POLICY

Therapeutic Riding lessons are planned with the individual's educational, physical, social, and/or recreational goals in mind and are taught by a PATH Intl. Certified Registered Instructor. Lessons may include warm-up exercises, skill development, and activities or games to reinforce goals. Classes are approx. 45 minutes in length and may include time for grooming, tacking, and ½ hour of riding dependent upon the participant's abilities. Classes may be group or individual depending on rider needs and schedule availability. Rising Hope is offering 3 sessions for the 2022 calendar.

Lesson fees:

$40/45 minute Class
(All additional sibling's fees will be $30/session.)

$30/30 minute Horsemanship Class (6 weeks with opportunity to progress)
Horsemanship class fees must be paid in full prior to class

Scholarship Program: There is a limited scholarship program. Please request an additional scholarship application if interested in partial or full scholarship.

We ask for cancellations at least 24 hours in advance, and only lessons cancelled at least two (2) hours in advance are eligible for a make-up. Lesson credit or refunds will not be given to more than 1 cancellation. While we do know that emergencies happen, we hope that you understand that your lesson fee supports our horses and allows us to continue to achieve our mission.
Classes may be cancelled due to inclement weather. All efforts will be made to contact participant within two hours of scheduled lesson time. For some participants and situations, an option may be that a stable horsemanship class can occur indoors. Lessons may be canceled if the wind chill reaches **25** degrees or below, or if the heat index reaches **90** degrees or higher. Cancellations because of inclement weather will be credited if make-up is not possible.

2023 SCHEDULING (Please check sessions of interest)

SPRING: TOTAL OF 8 WEEKS FOR SPRING SESSION

☐ April 3-May 26 (8 weeks)

SUMMER: TOTAL OF 9 WEEKS FOR SUMMER SESSION

☐ June 12-June 30 (3 weeks) Break July 3-July 7 ☐ July 10-August 18 (6 weeks)

FALL: TOTAL OF 9 WEEKS FOR FALL SESSION

☐ Sept 11-Oct. 6 (4 weeks) Break Oct. 9-Oct 13 ☐ Oct. 16-Nov. 17 (5 weeks)

CHECK AVAILABILITY:

Weekdays: ☐ **Mon.** ☐ **Tues.** ☐ **Wed.** ☐ **Thurs.** ☐ **Fri.**

Time: ☐ **AM** ☐ **PM**

Rising Hope Therapeutic Riding Center
Policies and Procedures

Limitations

It takes a special horse to become a part of the Rising Hope herd. Horses must demonstrate that they have the high level of patience, tolerance and the steady rhythmic gait required to be a good therapy horse. And like people, no two horses are alike. Each offers specific benefits to our riders, with their own needs and limitations. Therefore, it is critical that we do not exceed each horse's weight limit and work schedule.

Clothing

Equestrian activities require certain attire. Participants must wear long pants such as riding breeches or jeans to prevent chafing of legs. Footwear should consist of shoes or boots with a rounded toe and small heel. Riding boots with a heel must be worn when saddles without safety stirrups are used. Sandals, clogs or slip-on shoes are unacceptable. Parents or caregivers that accompany the participant to the farm are asked to wear appropriate footwear also. No jewelry is permitted. Safety helmets that meet ASTM-SEI requirements are required to be worn by all participants. Helmets will be available, but it is suggested that participants acquire their own helmet.

Safety and Conduct for Participants & Visitors

Rising Hope supports all efforts to promote safe conditions at its facility. Working with horses is a high risk activity. The following rules must be adhered to at all times:

- Participants are required to use gentle hands and feet while on or near any horse.
- Running, yelling, abusive or aggressive actions are not tolerated.
- No one may enter the paddock areas or stalls without permission from a staff member.
- Appropriate attire and footwear (no sandals) are required in barn and paddock areas.
- Hand-feeding of the horses is not allowed under any circumstance.
- Photography or video are not allowed without permission from staff.
- Children must be supervised by an adult at all times.
- No pets are allowed on the grounds.
- Smoking, alcohol or illegal substances are not allowed on the premises.
- Please respect that Rising Hope is located at a private farm and understand that the house is off-limits.
- Participants are only permitted on property during hours of operation.
- All visitors must sign a waiver/release form and remain in designated visitor areas
- Weapons and firearms are not permitted on RH private property.

I have read and understand all Rising Hope TRC policies and procedures:

Signature: ____ Date: ______________

Participant/Volunteer/Visitor's Signature

Rising Hope

(814) 933-8414 | 388 Reese Rd. Bellefonte PA, 16823 | risinghope.trc@gmail.com | risinghopetrc.com

RISING HOPE PARTICIPANT QUESTIONNAIRE

Name: ____

1. Briefly describe his/her disability. ____

____

2. What are the physical symptoms of the disability? ______________________________

3. What goals do you hope he/she will achieve by participation in this program

____

4. What other treatments or therapies has he/she undergone? *Please specify when/ how long*

____

____

5. How would you describe his/her concentration, attention span and general awareness

____

6. How would you characterize him/her? *Please check all that apply.*

☐ Happy ☐ Aggressive ☐ Easygoing ☐ Enthusiastic ☐ Passive ☐ Excitable ☐ Depressed

☐ Introverted ☐ Extroverted

7. Is he/she able to understand language? How does he/she communicate?

____

8. Is there a history of incontinence? ☐ No ☐ Yes ____________________________________

9. What positive reinforcements does he/she respond to

____

10. Please indicate any other areas of behavior and personality that will help us best communicate, understand and work with him/her.

____

____

Signature: ______________________________________ Date: ______________

Participant/Volunteer/Visitor's Signature

MEDICAL HISTORY & PHYSICIAN'S RELEASE
MUST BE COMPLETED BY PHYSICIAN

Name:		
DOB:	Height:	Weight:
Address:		
Name of Parent or Guardian:		
Primary Diagnosis:		Date of Onset:
Secondary Diagnosis:		Date of Onset:
Shunt Present: Yes No		Date of last revision:
Seizure Type: Controlled: Yes No		Date of last Seizure:

PHYSICIAN INFORMATION	
PLEASE LIST ALL CURRENT MEDICATIONS	
1.	Taken for:
2.	Taken for:
3.	Taken for:
4.	Taken for:
5.	Taken for:

Please indicate if patient has a problem and/or surgeries in any of the following areas.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			

Areas	Yes	No	Comments
Orthopedic			
Allergies			
Learning Disabilities			
Mental Impairment			
Psychological Impairment			
Incontinence			
Coordination			
Balance			
Independent Ambulation			
Crutches/Cane			
Wheelchair			
Braces			
Past/Prospective Surgeries			
Special Precautions/Needs			

PARTICIPANTS WITH DOWN SYNDROME – PLEASE NOTE AND COMPLETE

Due to the nature of the activity of horseback riding, no individual diagnosed with Down Syndrome can be accepted for riding instruction without proof of a negative diagnostic x-ray for Atlantoaxial instability. Please provide the following information:

Most recent cervical x-ray for AAI: ______Positive ______Negative Date of x-ray

PHYSICIAN INFORMATION

The following conditions, if present, may represent precautions and contraindications to the therapeutic horse riding. Please be sure to clearly identify and check the boxes if any of the following conditions are present and explain to what degree.

ORTHOPEDIC

Areas	Yes	No	Comments
Atlantoaxial instabilities			
Coxas Arthrosis			
Cranial Deficits			
Heterotopic Ossification			

Areas	Yes	No	Comments
Atlantoaxial instabilities			
Hip Subluxation and Dislocation			
Internal Spinal Stabilization Devices			
Kyphosis			
Lordosis			
Osteogenesis Imperfecta			
Osteoporosis			
Pathologic Fractures			
Scoliosis			
Spinal Fusion			
Spinal Instabilities/Abnormalities			
Spinal Orthoses			
Hip Subluxation and Dislocation			
Internal Spinal Stabilization Devices			
Kyphosis			
Lordosis			
Osteogenesis Imperfecta			

MEDICAL/SURGICAL

Areas	Yes	No	Comments
Allergies			
Cancer			
Diabetes			
Hemophilia			
Hypertension			
Peripheral Vascular Disease			
Poor Endurance			
Recent Surgery			
Serious Heart Condition			
Stroke			
Varicose Veins			

SECONDARY CONCERNS			
Areas	**Yes**	**No**	**Comments**
Acute exacerbation of chronic disorder			
Behavior problems			
Indwelling catheter			
Integumentary/Skin			
NEUROLOGIC			
Areas	**Yes**	**No**	**Comments**
Tethered Cord			
Chiari II Malformation			
Hydrocephalus/shunt			
Hydromyelia			
Paralysis due to Spinal Cord Injury			
Seizure Disorders			
Spina Bifida			

PHYSICIAN VERIFICATION	
PHYSICIAN VERIFICATION-PLEASE PRINT YOUR NAME, SIGN AND DATE-THANK YOU	
To my knowledge, there is **NO REASON** why this person cannot participate in supervised equestrian activities. However, I understand that Rising Hope will weigh the medical information above against the existing precautions and contraindications.	
Address:	
Phone:	
Physician Name/Title (Print):	
Signature:	Date: