Rider Application

To ensure coordinated care, Therapeutic Riding of Tri-Cities (TROT) staff and volunteers are provided with information about rider's abilities/disabilities.

Demographics

Rider's Name: _____ DOB: ___/___/___ Age: ____ Gender: M / F Height: ____ Weight: ____

Parents/Guardian/Caregiver (if applicable): _____ Phone: _____

Emergency Contact: Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____ School Name (if applicable): _____

Do you (rider) have previous riding experience? If so, please describe: _____

_____

Physical Skills

Is the rider proficient in the following physical skills?

Skills	YES	NO	Skills	YES	NO
Sits unassisted			Releases objects		
Stands independently			Bears weight on hands		
Walks unassisted			Bears weight on legs		
Runs unassisted			Uses bathroom independently		
Uses hands independently			Climb stairs		

Describe general balance: _____

Please list and explain ANY assistive devices that the rider may use at home or school: _____

_____

Notes on hearing or vision impairments: _____

Hand Preference (Circle One): Left Right No Preference

Sensory Skills

Please describe any sensitivity in the following areas:

Visual (Seeing): _____ Tactile (Touching): _____

Auditory (Hearing: _____ Olfactory (Smelling): _____

Proprioceptive (Movement): _____

Cognition and Processing Skills

Is the rider age appropriate in the following skills?

Educational/Cognitive Skills	YES	NO
Knows Numbers		
Knows Letters		
Knows Left/Right		
Knows Prepositions		
Communicates Feelings		
Makes Choices		

Language Skills	YES	NO
Makes sounds		
Uses words		
Combines two (2) or more words		
Speaks in complete sentences		
Understands “No”		
Letter sound identification		
Signs or uses gestures		
Uses picture symbols		

Social Skills	YES	NO
Recognizes Name		
Makes Eye Contact		
Waves/Says Hello/Bye		
Shares Toys/Items		
Knows Safety Awareness		
Interacts with Peers		
Appropriate Converstation		
Takes Turns		

Skills	(Circle One)		
Follows Directions	Often	Sometimes	Maybe
Attention to a Task	Poor (0-1min)	Fair (1-5 mins)	Average (5 mins)
Frustation Tolerance	Poor	Fair	Average
Problem Solving	Poor	Fair	Average

Personality Profile

Please describe personality and strengths: _____

What are some favorite activities or topics? _____

What are some fears or dislikes? _____

Psychological, emotional, behavioral, social issues: _____

Learning style (circle one):

Visual/learns by seeing Auditory/learns by hearing Kinesthetic/learns by doing

Successful strategies used at home (sensory modalities, behavioral, rewards, etc.): _____

_____

Please list any goals (i.e. what would you like to accomplish in therapeutic riding?): _____

_____

We (I) will be completing the Financial Aid Form (circle one): **YES** **NO**

Authorization for Emergency Medical Treatment Form

Rider's Name: _____ DOB _____/_____/_____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Physician's Name: _____ Address: _____ Phone: _____

Health Insurance Company: _____ Policy #: _____

Allergies to Medications: _____

Current Medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Caretaker (if applicable): _____ Phone: _____

In the event of an emergency where medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the TROT premises, I authorize TROT to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to be 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 physician. This provision will only be invoked if the person(s) above are unable to be reached.

Photo Release

For valuable consideration, acknowledged as received, I hereby grant permission and consent to Therapeutic Riding of Tri-Cities (TROT), its successors, licensees and assigns, to take still and moving photographs, digital images and films, including television footage (collectively "Work") of me:

I hereby further grant and assign to TROT the unrestricted and unbridled consent and authority, without further consent, inspection or approval, to use and reproduce the Work and to circulate, publish and publicize the Work by all means, including, without limitation all forms of media in newspapers, television, printed media, brochures, pamphlets, instructional materials, books, electronic media, website, social media (i.e., Instagram, Facebook, Twitter, Etc.) and clinical matters, and to alter the same without restriction, and without my inspection or approval. I hereby release TROT and its legal representatives and/or assigns from all claims relating to such Work.

With regards to the foregoing material, no inducement or promises have been made to me to secure my signature to this Release other than the intention of TROT to use or have used such Work for the primary purpose of promoting and aiding TROT and its purposes.

_____ NO, I do not give my consent to this Release

_____ YES, I do give my consent to this Release

Signature: _____ Date: _____

(Parent, legal guardian, or legally competent adult over 21)

Rider Release, Waiver of Liability, Assumption of Risks and Indemnity Agreement

In consideration of being permitted to participate in the Therapeutic Riding of Tri Cities, Instructional Riding for Special Needs persons herein by this reference ("Event") on the premises located at 6208 W. Argent Road, Pasco, WA., ("Premises"), the volunteer named below, individually and on behalf of any marital community, heirs, children, successors and assigns (collectively "Releasor") knowingly and voluntarily agrees to release, defend, indemnify and hold Therapeutic Riding of Tri Cities (TROT), a Washington Non-Profit Corporation, harmless, including without limitation, its employees, managers, directors, officers, agents, attorneys, successors and assigns (collectively "Releasee") as follows:

1. Prior to participating in the Event, Releasor shall inspect the Premises and the Event and inspect all related equipment to be used. If Releasor believes any of the foregoing are unsafe, Releasor shall immediately advise TROT management of such condition, and refuse to participate in the Event. If Releasor feels in any reasonable way during the Event that anything or any participant becomes unsafe, Releasor will immediately take all precautions to avoid all such dangers and REFUSE TO FURTHER PARTICIPATE AND ASSIST TO KEEP ANY PARTICIPANT OUT OF HARMS WAY.
2. Releasor fully understands and acknowledges the risks associated with participating in the Event at the Premises and fully and unconditionally assumes and accepts each such risk. Releasor hereby stipulates that Releasee has read the warning and understands the dangers of being around horses and children with spontaneous and possibly angry or violent tendencies where serious injury or death may occur.
3. Releasor knowingly and voluntarily agrees to defend, indemnify and hold Releasee harmless for any and all losses and/or damages to Releasor or third parties in the Event and third parties not associated with the Event, including, without limitation, any injury, disability, paralysis or death, regardless of cause and however caused and whether caused in whole or in part by the negligence of the Releasee named below.
4. Releasor hereby expressly acknowledges that any injuries received may be compounded or increased by negligent or delayed rescue or emergency operations over which Releasee may or may not have control and further assumes any and all risks associated with any such delayed rescue or emergency operations.
5. Releasor further expressly agrees that this Release, is intended to be as broad and as inclusive as permitted by the laws of Washington State, and that if any portion is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.
6. This release, waiver of liability, assumption of risk and indemnity agreement has legal effect and releasor is hereby informed of the right to seek independent legal review of this instrument prior to signing. If releasor fails to seek the advice of an attorney prior to signing this instrument, releasor shall be deemed to have knowingly and voluntarily waived any and all rights to seek legal review of this instrument, and any claim or cause of action that arises out of or is related to the participation of the event at the premises. If, despite this release, the releasor makes a claim against any of the covered parties that make up releasee, releasor shall reimburse releasee for any and all costs and expenses, including attorney's fees, that releasee has paid in order to hold releasee harmless.

RELEASOR HAS READ THIS RELEASE, WAIVER OF LIABILITY, ASSUMPTION OF RISK AND INDEMNITY AGREEMENT, FULLY UNDERSTANDS ITS TERMS, UNDERSTANDS THAT RELEASOR HAS FORFEITED SUBSTANTIAL RIGHTS BY SIGNING THIS RELEASE, WAIVER OF LIABILITY, ASSUMPTION OF RISK AND INDEMNITY AGREEMENT, HAS SIGNED THIS INSTRUMENT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT, ASSURANCE OR GUARANTEE OF ANY KIND

BEING MADE TO RELEASOR, INTENDS THE SIGNATURE BELOW TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY, INCLUDING ANY GROSS NEGLIGENCE OF RELEASEE, AND KNOWINGLY AND VOLUNTARILY WAIVES ANY AND ALL CAUSES OF ACTION AGAINST RELEASEE TO THE GREATEST EXTENT ALLOWED BY LAW.

Premises located at: 6208 W. Argent Road, Pasco, WA 99301

_____	_____	_____
Signature of Releasee (TROT)	**Print Name of Releasee**	**Date**
_____	_____	_____
Signature of Releasor	**Print Name of Releasor**	**Date**
_____	_____	_____
Parent/Guardian Signature (If Releasor is a Minor)	**Print Name of Parent/Guardian**	**Date**

Physician's Release/Medical History

Rider's Name: _____ DOB: ___/___/___ Age: ____ Gender: M / F Height: ____ Weight: ____

Name of Parent(s)/Guardian: _____

Diagnosis: _____ Date of Onset: _____

- *For person with Down Syndrome: Cervical x-ray for Atlanto-Axial Instability*

Positive: _____ Negative: _____ X-Ray Date: _____

Tetanus Shot (circle one): YES NO Seizures: Type: _____ Controlled? _____ Date of last Seizure: _____

Medications: _____

AREAS	NORMAL	PROBLEMS/ DEFICITS	COMMENTS/ SURGERIES	AREAS	NORMAL	PROBLEMS/ DEFICITS	COMMENTS/ SURGERIES
Auditory				Allergies			
Visual				Learning Disability			
Speech				Mental Impairment			
Cardiac				Physical Impairment			
Pulmonary				OTHER			
Neurological					YES	NO	
Othropedic				SHUNT			
Scoliosis				GI TUBES			
				CATHETHER			

Mobility Skills	YES	NO
Independent Ambulation		
Braces		
Crutches		
Wheelchair		

Other special precautions: _____

Contraindications exist for anyone where the movement of the horse or the environment will make a patient worse. Including but not exclusive to: advanced osteoporosis, osteogenesis imperfecta, severe scoliosis, acute painful conditions, unstable bones or joints, severe fears, and advanced atlan:to-axial instability as sometimes found in Down's Syndrome or juvenile rheumatoid arthritis.

In my opinion this patient has no contraindications and may participate in supervised equestrian activities. In conjunction with these activities, I concur in the referral of the participation to a PT/OT/or SLP or other health care professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian or therapy program. I understand that the final decision regarding acceptance rests with the TROT staff, upon due consideration of the rider's special needs, precautions and contraindications, and the safety of the rider, staff, volunteers, and horses. **This form MUST BE signed and stamped by a physician and turned into TROT prior to beginning session.**

Physician's Name (please print): _____ Signature: _____ Phone: _____

Physician: Please return form to parents or mail to TROT, 5208 W. Argent Road, Pasco, WA 99301
Parents: Please return form into TROT prior to starting classes

Therapist Evaluation

To be completed by rider's primary therapist (circle one): PT OT SLP

_____ Does not apply. If applicant is NOT receiving PT/OT/SLP services currently, please sign below:

Signature: _____ Date: ____/____/____

Name: _____ DOB: ____/____/____ Disability: _____

Address: _____ City: _____ State: _____ Zip Code: _____

School: _____ Therapist: _____ Phone: _____

Muscle Tone: _____ Room/JT. Deformities: _____

Balance Coordination: _____ Self –Help Skills: _____

Mobility: _____ Assistive Devices: _____

Posture/Scoliosis: _____

Associated Reactions/Abnormal Relations: _____

Comprehension of Verbal Instructions: _____ Speech/Discourse: _____

Exercises or positions to avoid: _____

Other special precautions: _____

Present Goals of PT/OT/SLP program: _____

Therapist's Name (please print): _____ Signature: _____ Phone: _____

Therapist: Please return form to parents or mail to TROT, 5208 W. Argent Road, Pasco, WA 99301
Parents: Please return form into TROT prior to starting classes