



# Special Equestrians, Inc.

Thank you for your interest in Special Equestrians. Enclosed, please find the forms needed for a new student. We presently have a waiting list, so please send your completed application with an original signature as soon as possible. You can send the physician's statement upon it's completion. The applications on our waiting list are taken on a first come, first serve basis. We must have all forms completed and returned in order to set up an evaluation which is scheduled when an opening is apparent.

## Class Details:

- We usually hold 9 week terms in the spring and fall, and a six week term over the summer.
- The student rides one time per week for approximately 30-45 minutes. Each rider starts with 3-4 volunteers, side-walking and leading.
- They progress at their own speed and according to ability. Many move on to ride independently.
- We incorporate many different aspects of riding. They can learn to ride in order to compete, or they can ride for pleasure as in trail riding. For many, just sitting on the horse and taking a walk is very beneficial.

## Cost:

- Spring and Fall Terms (9 weeks)                      \$150
- Summer Term (6 weeks)                                      \$100

\* Scholarships are always available to those in need.

We are looking forward to your participation in our program.

Sincerely,

Kathleen M. Claybrook  
Executive Director

**1215 Woodward Drive, Indian Springs, AL 35124**  
205/987-WHOA(9462)



# Special Equestrians, Inc.

## Rider's Registration and Release Form

Rider: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Hm Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Wife/Mother: \_\_\_\_\_ Employer: \_\_\_\_\_ Wk Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Husband/Father: \_\_\_\_\_ Employer: \_\_\_\_\_ Wk Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### Liability Release

**The above-indicated rider** would like to participate in the Special Equestrians, Inc. program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/ my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Special Equestrians, Inc., its officers, trustees, Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees, agents or representatives and Indian Springs School, its Officers, trustees, Board of Directors, representatives, agents or employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Special Equestrians, Inc. program. I agree to fully disclose to Special Equestrians, Inc. any physical or emotional/behavioral conditions that would prevent or limit the child's participation in the program.

**Warning: Under Alabama Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to the Equine Activities Liability Protection Act.**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Client, Parent or Guardian

### Photo Release

I hereby consent to and authorize the use and reproduction by Special Equestrians, Inc. of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Client, Parent or Guardian

### Scholarship Request

Reason for Scholarship Need \_\_\_\_\_

One Time \_\_\_\_\_ Ongoing \_\_\_\_\_ Amount of Scholarship needed: \_\_\_\_\_%

Signature of Applicant/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



# Special Equestrians, Inc.

## Rider's Authorization for Emergency Medical Treatment Form

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 Special Equestrians, Inc. to:

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

Client's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

If I cannot be reached, 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 below is unable to be reached.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_

Student, Volunteer, 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 or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Non-Consent Signature \_\_\_\_\_

Student, Volunteer, Parent or Guardian

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_



# Special Equestrians, Inc.

## Cover Page of Physician's Statement

Dear Health Care Provider,

Your patient, \_\_\_\_\_, is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. 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  
Coxa Arthrosis  
Cranial Deficits  
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  
Poor Endurance  
Skin Breakdown  
Medications - i.e. photosensitivity

### **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 rider's participation in equine assisted activities, please feel free to contact the center at the address/phone indicated below.

Sincerely,

Special Equestrians, Inc.

**1215 Woodward Drive, Indian Springs, AL 35124**  
**205/987-WHOA**



# Special Equestrians, Inc.

## Participant's Medical History & Physician's Statement

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Past/Prospective Surgeries: \_\_\_\_\_

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: \_\_\_\_\_

For those with Down Syndrome: AtlantoDens Interval X-rays, date: \_\_\_\_\_ Result: + --

Neurologic Symptoms of AtlantoAxial Instability: \_\_\_\_\_

*Please indicate current or past special needs in the following systems/areas, including surgeries:*

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

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

Name/Title: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_



# Special Equestrians, Inc.

Dear Rider, Parent or Guardian,

In order to safely provide this service, our center requests that you complete/update the attached Health History annually. 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  
Coxa Arthrosis  
Cranial Deficits  
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  
Poor Endurance  
Skin Breakdown  
Medications - i.e. photosensitivity

## **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 rider's participation in equine assisted activities, please feel free to contact the center at the address/phone indicated below.

Sincerely,

Special Equestrians, Inc.

**1215 Woodward Drive, Indian Springs, AL 35124  
205/987-WHOA**



# Special Equestrians, Inc.

## Health History

(To be completed annually by participant or legal guardian)

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Past/Prospective Surgeries: \_\_\_\_\_

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: \_\_\_\_\_

Medications (include prescription, over-the-counter & note any side effects due to heat, etc., ) \_\_\_\_\_

\_\_\_\_\_

*Please indicate current or past special needs in the following systems/areas, including surgeries:*

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

To my knowledge there is no reason why I/this person cannot participate in supervised equestrian activities. However, I understand that the NARHA center will weigh the medical information above against the existing precautions and contraindications to determine whether I/this person shall be eligible to participate in Equine Activities at Special Equestrians, Inc. I concur with a review of this person's abilities by the staff of Special Equestrians, Inc., in the implementing of an effective equestrian program.

Participant/Legal Guardian Name (Please Print): \_\_\_\_\_ Relationship \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_



# Special Equestrians, Inc.

## Understanding the Participant

Please list strengths and weaknesses in the following areas and be mindful of riding the horse.

Physical Aspects of Disability (i.e.balance, muscle strength, ability to sit independently, stand, reach, etc)

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Cognitive Aspects of Disability (understanding simple or complex directions)

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Behavioral Aspects (Response to direction, frustration, triggers that set off negative responses & calming techniques)

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Social Aspects (Ability to function in a group setting )

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Ability to Communicate (i.e. non-verbal, makes sounds, length of sentences, sign language)

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Goals (Why are you applying for participation, what would you like to accomplish over the short term and long term)

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