Rider/Participant Application Form

PARTICIPANT NAME: _____

Address: _____

DOB: _____ Age: ____ Height: _____ Weight: _____ (website and policies for guidelines) Gender: M F

Employer/School: _____

PARENT/LEGAL GUARDIAN (if under age 18): _____

Address (if different from above): _____

Phone: (H) _____ (C) _____ (W) _____

EMAIL ADDRESS: _____ (***Email is our primary form of communication***)

_____ I do not have access to email, please contact me via: _____

INDIVIDUAL RESPONSIBLE FOR SCHEDULING AND TRANSPORTATION: _____

Address (if different than above): _____

Phone: _____ Email: _____

INDIVIDUAL/AGENCY RESPONSIBLE FOR PAYMENT: _____

Address (if different than above): _____

Phone: _____ Email: _____

IRIS Eligible: Yes No IRIS Consultant Name: _____

Phone: _____ Email: _____

REFERRAL SOURCE: _____Phone: _____

How did you hear about REINS? _____

Describe your previous riding experience and current level of riding: _____

_____

Describe your horseback riding or other program goals: _____

_____

What specific physical, cognitive and /or emotional goals do you have? _____

_____

Is there anything that would be helpful for the staff or volunteers to know about you or your learning style?

_____

_____

Do you have a family member/other person who might be interested in volunteering for class or in another capacity?

Name: _____ Phone: _____ email: _____

Please attach Recent Photo and indicate T-Shirt Size

Youth *SM___MD___LG___* ***Adult*** *SM___ MD___LG___XL___XXL___*

Weeks wishing to participate:
June 11____ June 18____ June 25____ *NO CLASS WEEK OF JULY 4* July 9____ July 16____ July 23____July 30____
Aug 6____Aug 13____ Aug 20_____

Possible Reasons for Participant Discharge

Please be advised of the following reasons that may lead to discharge from the REINS, Inc. program.

1. Participant displays a condition listed by Professional Association of Therapeutic Horsemanship International (PATH) as a contraindication to therapeutic riding.
2. Participant's potential to maintain head and neck control in a sitting position presents a safety concern.
3. Inability to follow directions is interfering with progress toward treatment goals.
4. Uncontrolled and inappropriate behavior that may constitute a safety risk to participants, volunteers or staff.
5. Participant exceeds weight limit that can safely be managed by staff, volunteers, and/or horses.
6. Any change in the participant's medical, physical, cognitive or emotional condition that makes therapeutic riding inappropriate.
7. Three scheduled sessions are missed without prior cancellation .
8. Nonpayment after first lesson of each session.

_____ Date: _____

Signature of participant, parent or legal guardian

Please note the following important REINS policies:

1. Scheduling is done on a first come first served basis. Please send your completed Participant (Rider) Application Form, in its entirety, and payment by the due date.
2. You will receive a session confirmation prior to the beginning of the session(s) that you have signed up for.
3. All forms and information are kept strictly confidential.
4. To accommodate everyone, lessons must start on time and may not be interrupted if you arrive late.
5. Per the advice of our veterinarian and Professional Association of Therapeutic Horsemanship Internationals' precautions and contraindications, it is necessary for us to limit the weight that our horses carry. All riders must be 220 lbs. or less for balanced independent riders, 200 lbs. if side walker assistance is needed for balance. Therefore, it is mandatory that the height/weight portion of the forms be filled out accurately prior to participation. Participation in our riding program for the above mentioned reasons and others remain at the discretion of the Director(s) of the program and veterinarian.
6. Spectators under the age of 18 must be supervised by parent/guardian while at the REINS facility. Parent/guardian must take full responsibility for any/all incidents arising from lack of direct supervision. Direct supervision is not the responsibility of REINS, Inc. or any of its employees, volunteers, other parents/guardians, riders or visitors.
7. Parents/guardian or other authorized staff must remain at the REINS facility during the full course of their participant's lesson.

My signature below indicates that I have read, understand and will comply with the above listed REINS policies:

_____ Date: _____

Signature of participant, parent or legal guardian

Liability Release*

_____ (participant's name) would like to participate in the REINS, Inc. program. I acknowledge the risks and potential for risks of horseback riding and related activities. 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 Majestic Meadows Dairy LLC and REINS, Inc., its Board of Directors, instructors, therapists, aides, volunteers, facility owners, and/or staff for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in REINS, Inc. activities.

_____Date: _____
Signature of participant, parent or legal guardian

Photo Release*

____ I Do ____ I Do Not

Consent to and authorize 1) REINS, Inc. Equine Assisted Activities and Therapies may use my (my child's) photograph or image in its print, online and video publications; 2) release REINS, Inc. Equine Assisted Activities and Therapies, its employees and any outside third parties from all liabilities or claims that I might assert in connection with the above-described activities and 3) I waive any right to inspect, approve or receive compensation for any materials or communications, including photographs, videotapes, DVDs, website images or written materials, incorporating photos/images of me (my child).

_____Date: _____
Signature of participant, parent or legal guardian

Permission to Share Information with Lesson Volunteers*

____ I Do ____ I Do Not

Give permission to REINS, Inc. instructors to share information they deem appropriate regarding me/my son/my daughter/my ward and his/her disability/lesson goals/communication style, including any specific needs or precautions, with the lesson volunteers. This release is valid for one year and can be revoked, in writing, at my request.

_____Date: _____
Signature of participant, parent or legal guardian

Releases will be considered ongoing with an open ended date and will remain in place for subsequent enrollments unless an end date is noted.

Authorization for Emergency Medical Treatment

Participant's Name: _____ DOB: _____ Phone: _____

Address: _____City: _____Zip: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility _____

Health Insurance Company: _____Policy # _____

Allergies to medications or foods: _____

Current medications: _____

In the event of an emergency contact:

Name: _____ Relation: _____

Phone #1:_____Phone #2:_____

Name: _____ Relation: _____

Phone #1:_____Phone #2:_____

Name: _____ Relation: _____

Phone #1:_____Phone #2:_____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services or while being at the REINS facility, I authorize REINS, Inc. to:

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

Medical Treatment Consent Plan

This authorization includes x-rays, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician in the event of illness or injury while receiving services. This provision will only be invoked if the person(s) above is unable to be reached.

Date: _____ Consent Signature: _____
Participant, parent or legal guardian (Signed in the presence of center staff)

Medical Treatment Non Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury while receiving services. In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

Date: _____ Non Consent Signature: _____
Participant, parent or legal guardian (Signed in the presence of center staff) **Records Access Authorization**

TO WHOM IT MAY CONCERN:

Pursuant to the regulations under HIPAA, this memorandum is authority for you to provide to REINS, Inc. or their authorized representative, all medical records, psychiatric records, hospital records, x-rays, technicians' reports, pharmacy or drugstore records, medical charts, office's notes, physician's reports or other related medical information related to the examination and treatment of _____ (name of participant).

I, _____ (name of participant, parent or legal guardian), understand that the information used or disclosed may be subject to redisclosure by the person or class of persons or facility receiving it, would then no longer be protected by federal regulations.

I, _____ (name of participant, parent or legal guardian), may revoke this authorization by notifying REINS, Inc. in writing of my desire to revoke it. However, I understand that my action already taken in reliance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

A photocopy of this authorization may be accepted with the same force and effect as an original. This authorization is valid for one year.

Dated: _____

Signature of participant, parent or legal guardian: _____

DOB: _____

SS# _____

State of Wisconsin, County of _____

On this day of _____, 2017, before me personally came and appeared to me known and known to the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that she/he executed the same.

_____
Witness of legal age

Send this form along with the following pages which are to be completed by the participant's physician.

Medical History and Medical Statement

Must be completed by physician

It is very important that we have accurate height and weight for the appropriate assignment of horses. It must be current within three months of June 1, 2017.

Date: _____

Dear Physician: _____

Your patient, _____is interested in participating in supervised equestrian activities,
(Participant's name)

In order to safely provide this service, REINS, Inc. requires that you complete the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindication to therapeutic horseback riding. Therefore, when completing these forms, please note whether the conditions are present and to what degree.

Weight: _____ Height: _____ DOB: _____

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: _____

Date of last Hip Radiograph: _____Result (please describe) _____

Special precautions/needs: _____

_____

Mobility:

Independent Ambulation Y N Assisted Ambulation Y N

Wheelchair Y N

Braces/assistive devices: _____

What physical, cognitive and/or emotional goals do you have for this participant? _____

_____

Is there any further information that you think REINS, Inc. should know regarding the medical condition of this

individual? _____

_____

Patient's Name: _____Date: _____

Please indicate whether these conditions are present and to what degree. Please attach any necessary additional information.

Orthopedic

___ Atlantoaxial instability – include neurologic symptoms

___ Coxa Arthrosis

___ Cranial Defects

___ Heterotopic ossification/Myositis Ossificans

___ Joint subluxation/dislocation

___ Osteoporosis

___ Pathologic fractures

___ Spinal fusion/fixation

___ Spinal instabilities/abnormalities

Neurologic

___ Hydrocephalus/shunt

___ Seizure

___ Spina Bifida

___ Chiari II malformation

___ Tethered cord

___ Hydromyelia

-**Other**

___ Age –under 4 years

___ Indwelling catheters

___ Skin breakdown

Medical/Psychological

___ Autism.

_____ ADHD

___ Allergies

___ Animal abuse

___ Physical/Sexual/Emotional Abuse

___ Blood Pressure control

___ Dangerous to self or others

___ Exacerbations of medical conditions

___ Fire Settings

___ Heart conditions

___Poor endurance

_____ Medications
(ie. Photo Sensitivities)

Atlantoaxial Instability or focal neurologic disorder clearance
Date: _____

___Down's Syndrome
(Physician's AAI clearance required yearly)

Medical/Psychological (Continued)

___Substance abuse

___Thought control disorder

___Varicose veins

___ Hemophilia

___ Medical Instability

___ Migraines

___ PVD

___Respiratory Compromise

___Recent surgeries

___Weight control disorder

_

Health History

Diagnosis **Date of Onset:**

Please indicate current or past special needs in the following areas, including surgeries

	YES	NO	Comments
Special Needs			
Allergies			
Auditory/hearing			
Balance			
Cardiac/heart			
Circulatory			
Cognitive/thinking			
Emotional/Psychological			
Immunity			
Integumentary/skin			
Learning Disability			
Muscular			
Neurologic			
Orthopedic/bone/joint			
Pain			
Pulmonary/breathing			
Speech/communication			
Tactile/touch Sensation			
Visual			

After careful review of _____ (participant's name) medical history and consideration of the risks of equestrian activities, to my knowledge, there is no reason why this person cannot participate in supervised equestrian activities.

Printed Name_____ Title: _____ MD DO NP PA Other

Signature: _____Date: _____

Phone: _____ Email: _____

Address: _____

License/UPIN Number: _____

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equestrian activities, please feel free to contact REINS, Inc. at (920)946-8599.

PLEASE MAIL COMPLETED FORMS TO: REINS, Inc. PO Box 68 Sheboygan Falls, WI 53085-0068