



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 its 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) \$145
- Summer Term (6 weeks) \$ 95

* 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: _____

Home 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.

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.

Health History

(To be completed annually by participant or 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			

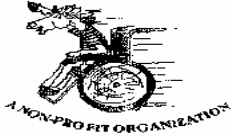
To my knowledge there is no reason why I/this participant cannot participate in supervised equestrian activities. I understand that the NARHA center will weigh the medical information given against the existing precautions and contraindications.

Name: _____ 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)

Cognitive Aspects of Disability (understanding simple or complex directions)

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

Social Aspects (Ability to function in a group setting)

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

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