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. An evaluation will be scheduled upon receipt of all forms. The applications on our waiting list are taken on a first come, first serve basis.

Class Details:

- Therapeutic Riding: We usually hold 2-6 week terms in the spring, and fall. Additionally we hold camps and other activities over the summer. The student rides one time per week for approximately 30-45 minutes. Most riders start with 3 volunteers, side-walking and leading. They progress at their own speed and according to ability. Some may move on to ride independently. Weight restriction of 200 pounds.
- Horsemanship: Teaches the participant about care of the horse such as grooming and leading. This is an unmounted activity. They attend one time per week for approximately 45 minutes.
- Horseabilities: Uses a mechanical horse to give the participant the benefit of the movement of a horse. Ideal for those that cannot be on a live horse due to medical or physical restrictions. The participant attends 1 time per week for approximately 30 minutes.
- Summer Camps: Incorporate Therapeutic Riding and Horsemanship. Participants attend 4 days from 9-11:30.

Cost:

• Spring, Fall Terms (6 weeks)	$180
• Summer Camp (4 days 9-11:30)	$250
• Horseabilities	$180

* Tuition Discounts may be available to those in need.

We are looking forward to your participation in our program.

Sincerely,

Kathleen M. Claybrook

Kathleen M. Claybrook
Executive Director

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

Special Equestrians, Inc.

Participant's Application and Release Form

Rider:_____

Date of Birth:_____ Age:_____ Height:_____ Weight:_____ Gender: M F

Street:_____ City:_____ State:_____ Zip Code:_____

Hm Phone:_____ Email:_____

Wife/Mother:_____ Employer:_____ Wk Phone:_____ Cell Phone:_____

Husband/Father:_____ Employer:_____ Wk Phone:_____ Cell Phone:_____

Legal Guardian if different from Parent:_____ Phone:_____

Caregivers:_____ Phone_____

Address (if different from above)_____

In case of emergency Contact:_____
Phone:_____

Physician's Name:_____ Phone: _____

How did you find out about Special
Equestrians:_____

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:_____
Participant, Parent or Guardian

Photo Release

I hereby ☐ **Consent** ☐**Do Not** 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:_____
Participant, Parent or Guardian

Participant'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.

Participant'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 "lifesaving" 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
Scoliosis

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: _____ Circle Result: + --

Neurologic Symptoms of AtlantoAxial Instability Circle Y N _____

Please indicate current or past special needs in the following systems/areas, including surgeries: (All participants will have special needs in at least one area)

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Scoliosis			
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 PATH, Intl. center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH, Intll.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
Scoliosis

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: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____

Shunt Present: Y N Date of last revision: _____

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.,) _____

_____

Special Precautions/Needs: _____

Please indicate current or past special needs in the following systems/areas, including surgeries: (All participants will have special needs in at least one area)

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Scoliosis			
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 PATH Intl. 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)

_____

_____

_____

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 (Reason you are applying for participation and what you hope to achieve)

Short Term _____

Long Term _____

Special Equestrians, Inc.

Tuition Discount Request

Special Equestrians, Inc. will make every effort to provide services to all participants whose application is accepted. We are only able to do so through fund raising events and the generosity of our supporters, sponsors and grantors. Tuition covers just a fraction of the cost of providing services. While we would like to continue to provide discounts to all who qualify, we find that resources are limited and ask that all participants pay as much as they are able.

All applications must be submitted by February 15th and will remain in place for the current year. A newly completed Tuition Discount Application will need to be completed annually by February 15th. Applicants will be notified of the outcome by February 28th of each year.

- All information provided on the application will be kept strictly confidential.
- All applications will be reviewed and funds will be distributed on the basis of need, number of requests and available funds. In addition to family income, additional factors will be considered, such as number of dependents in the household and extraordinary medical expenses or circumstances.
- Participants who receive tuition assistance and have more than 1 "no-show"(no notification given for missing a class) will be subject to forfeiting the current term discount and becoming ineligible for future assistance.
- If there is a change in income during the year, please notify the office in writing at the address below.
- We realize that special circumstances come about throughout the year and we will make accommodations if necessary.

If you have any questions regarding the process or your eligibility, please feel free to give us a call.

Special Equestrians, Inc.
Tuition Discount Application

Date_____

Participant Name_____

Address_____City_____ State _____ Zip_____

Activity: ❑ Therapeutic Riding ❑ Horseabilities ❑ Hippotherapy

Type of Discount: ❑ One Time Request ❑ Ongoing

Amount of tuition discount requested: ❑ 25% ❑ 50% ❑ 75% ❑ 100%

Mother's Name _____ Phone_____

Address_____ City _____ State_____ Zip_____

Annual Income _____ Occupation_____ Employer_____

Employer Address_____ Phone_____

Father's Name _____ Phone_____

Address_____ City _____ State_____ Zip_____

Annual Income _____ Occupation_____ Employer_____

Employer Address_____ Phone_____

Total Annual Earned Income Category (select one)

❑Less than $15,000 ❑ $15,000 - $25,000 ❑ $25,000 - $50,000 ❑ Over $50,000

Additional aid or support other than earned income: _____

Number of Dependents in Household: Adults _____ Children _____

Primary Residence: _____Monthly Payment_____❑ Owned ❑ Financed ❑ Rented

Additional Property: _____ Monthly Payment_____ ❑ Owned ❑ Financed ❑ Rented

Vehicles: Year:_____ Make/Model:_____ Monthly Payment:_____ ❑ Owned ❑ Financed ❑ Rented

Year:_____ Make/Model:_____Monthly Payment:_____ ❑ Owned ❑ Financed ❑ Rented

Please identify other financial obligations or factors that should be considered with this application (may attach additional sheets):

_____

I, THE PARTICIPANT, PARENT OR LEGAL GUARDIAN CERTIFY THAT ALL OF THE INFORMATION THAT I HAVE PROVIDED ON THIS APPLICATION IS TRUE, COMPLETE AND ACCURATE.

_____ _____

Signature & Relationship to Participant Date

Approved by:
Special Equestrians, Inc.

_____ _____

Its: Date