Mailing: P.O. Box 462, Nursery, TX 77976
Physical: 557 Love Road, Victoria, TX 77905
Phone/Fax: 361-578-8182
theridingtherapycenter@gmail.com
www.TheRidingTherapyCenter.org

Welcome to The Riding Therapy Center!

We welcome your interest in The RTC's Equine Services for Heroes Program and we look forward to working with you to help you accomplish your goals and enjoy your time spent in and outside of the arena through the many benefits of therapeutic riding and horsemanship.

The RTC receives funding through various sources to be able to provide this program for military veterans. Each participant has gained numerous benefits from their work with The RTC's therapy horses, staff and volunteers such as increased flexibility, physical stamina, decreased pain and anxiety levels and an improvement in general mood and daily outlook on life.

In order to continue to provide an enjoyable, safe and effective environment for our clients, The RTC has established some guidelines and requirements for acceptance into the program:

- To protect our clients, volunteers and horses there are weight guidelines and requirements. Please refer to the Client Guidelines portion of this packet.
- The Client Application and Physician Packet must both be fully completed and signed by the appropriate individuals and are required to be updated annually.
    - All forms must be returned to The RTC's offices before you will be contacted for initial enrollment into the program.
    - The RTC will then contact you to schedule a New Client Screening and Evaluation with our Physical Therapist.
- Please read the Client Application and Guidelines in full.
- If you have access to email, please note it on the application form as a great deal of information is corresponded electronically.

If you have any questions please feel free to contact The RTC by the information listed at the top of these forms.

We look forward to working with you and your family!

Mailing: P.O. Box 462, Nursery, TX 77976
Physical: 557 Love Road, Victoria, TX 77905
Phone/Fax: 361-578-8182
theridingtherapycenter@gmail.com
www.TheRidingTherapyCenter.org

PROGRAM OVERVIEW

Equine Assisted Activities and Therapies (EAAT) are any specific center activity, such as **therapeutic riding**, mounted or ground activities, grooming and stable management, etc. in which the center's clients, participants, volunteers, instructors and equines are involved. Research shows that individuals of all ages who participate in EAAT can experience physical, cognitive and emotional rewards.

The RTC is a Premier Accredited Center of the Professional Association of Therapeutic Horsemanship (PATH Intl) and abides by their strict guidelines and policies in order to provide the most beneficial and safe experience for each client. PATH Intl is committed to being a global authority, resource and advocate for EAAT that inspire and enrich the human spirit. As the premier professional membership organization, PATH Intl. establishes and oversees standards for the accreditation of centers and the certification of instructors and equine specialists.

Programs Offered at The RTC:

- *Therapeutic Riding* - Mounted horseback riding with the purpose of contributing positively to cognitive, physical, emotional and social well-being of people with disabilities through the teaching of horsemanship skills.

- *Unmounted or Ground Activities* – for those unable to ride.

- *Equine Services for Heroes* - Therapeutic Riding with the purpose of positively impacting the lives of Veterans with the physical, social and emotional therapeutic benefits of horse to help them adjust to their post-war lives.

The RTC Organization:

The RTC is a 501(c)(3) nonprofit organization governed by a volunteer Board of Directors. Primarily volunteer-based, The RTC operates through paid staff and the dedicated support of numerous volunteers. We rely on the financial support of donations, granting foundations and proceeds from special events and client fees for continued operations. All instructors at The RTC are certified through PATH Intl and volunteers are specially trained for program activities in order to provide the safest and most beneficial experience possible.

Mailing: P.O. Box 462, Nursery, TX 77976
Physical: 557 Love Road, Victoria, TX 77905
Phone/Fax: 361-578-8182
theridingtherapycenter@gmail.com
www.TheRidingTherapyCenter.org

CLIENT GUIDELINES

Please read through these guidelines thoroughly and keep for future reference.

Sessions: The RTC operates in year round 8-Week Sessions (Winter, Spring, Summer I, Summer II, and Fall). Each Session is consecutive weekly lessons (excluding most holidays) with one week set aside at the end for any makeup lessons needed due to illness, weather cancellations, etc. Each Makeup Week is followed by one week off to allow the therapy horses to rest. Please see the calendar section on the website for Session Dates.

New Client Registrations: All new clients will be screened and evaluated by The RTC's physical therapist and instructors prior to being accepted into the program. All paperwork (Client Application and Physician Packet) must be completed, signed and returned to The RTC's office before you will be contacted for this screening and evaluation. Acceptance into the program is dependent upon the schedule, appropriate horses for the client and safety precautions and contraindications. The RTC reserves the right to refuse or discontinue serves when necessary.

Clothing Requirements for Clients:

- All riders must wear an ASTM/SEI approved equestrian helmet for all mounted activities.
- Long pants or appropriate clothes for your class or weather. Pants or shorts of "slick" material are not acceptable as they cause the rider shift/slip throughout the lesson.
- Closed-toed shoes or boots. Riding boots or sturdy hard-soled shoes with a ¼ inch heels are required to be worn when using tack without safety stirrups. Alternative footwear may be acceptable under specific circumstances which will be considered on an individual basis.

Weight Guidelines:

Please be aware that most program horses have a rider weight limit of 225 pounds. Generally, the client plus tack should not exceed 20% of the horse's weight, however, some horses have further limitations. For the safety of the client, horses, volunteers and staff, clients may not be allowed to participate in mounted activities if their weight exceeds these limitations.

Attendance and Cancellation Policy:

When you are admitted for participation in The RTC's program, volunteers, horses and staff are assigned and look forward to working with you each week. Please be considerate of their time and arrive promptly for your scheduled lesson. The amount of time you are late is deducted from the total lesson time. *Veterans who are more than 10 minutes late for their lesson may not be allowed to ride.*

All client cancellations must be made *at least 24 hours in advance*. Clients may notify The RTC of their cancellation via the office phone (361-578-8182), email (theridingtherapycenter@gmail.com) or through notification of the appropriate instructor (contact information available at The RTC). *Any combination of three consecutive "no-shows" or cancellations without a 24 hour advance notice will result in the dismissal of the client from The RTC's program.*
Weather cancellations will be made by The RTC's staff at least two hours prior to the lesson time. All clients/parents/guardians/caregivers will be notified via their preferred mode of contact as designated on the Client Application.

Mailing: P.O. Box 462, Nursery, TX 77976
Physical: 557 Love Road, Victoria, TX 77905
Phone/Fax: 361-578-8182
theridingtherapycenter@gmail.com
www.TheRidingTherapyCenter.org

Client Fees and Payment:

Preference	Lesson Format	Lesson Length	8-Week Session Fee
	Private (1 rider/class)	60 minutes	$400
	Semi-Private (2 riders/class)	45 minutes	$280
	Group (3-5 riders/class)	45 minutes	$240
	Group (3-5 riders/class)	30 minutes	$160
	Equine Services for Heroes	45 minutes	No Cost

The RTC appreciates and depends on collaborative cooperation from all participants in order to continue funding for the Equine Services for Heroes Program.

- All Veterans receiving funding through the Wounded Warrior Project will be required to complete a pre-participation and post-participation survey.
- All Veterans receiving funding through the Wounded Warrior Project must be approved as WWP Alumni before attending the Physical Therapist Screening and Evaluation.
- It is your responsibility to provide The RTC with updated email and/or mailing addresses.
- Proof of military service is required to participate in The RTC's ES4H Program. Although we do not need to keep a copy of the ID, we will need to see it and sign this form with you before your first class begins.

Type of ID: __________________ Status: _________________ Exp. Date: _______________
(Examples: Military ID, DD214) (Examples: Active, Retired)
Printed Name: ____
Signature: ____ Date: ________________

Verified by The RTC Staff
Printed Name of The RTC Staff: ____
Signature of The RTC Staff: ____ Date: __________

Contact Information:

- ○ Preferred email address. Important notifications are emailed via secure email.
  ____
- ○ I do not have an email address.
- ○ I have read and agree to The RTC's guidelines and policies, including the Attendance and Cancellation Policy included in this packet.

Signature: ____ Date: _______________
(Participant or Parent/Guardian/Caregiver)

Mailing: P.O. Box 462, Nursery, TX 77976
Physical: 557 Love Road, Victoria, TX 77905
Phone/Fax: 361-578-8182
theridingtherapycenter@gmail.com
www.TheRidingTherapyCenter.org

CLIENT APPLICATION AND HEALTH HISTORY

To be completed by Client, Parent, Guardian or Caregiver

First Name: ______________________ Last Name: _______________________ MI: ________

DOB: ______________ Height: _____________ Weight: _____________ Gender: M F

Address: ________________________ City: ____________ State: _____ Zip Code: __________

Preferred Phone (Main): ____________________ Other Phone: _______________________

Parent/Guardian/Caregiver (if applicable): ____

Address (if different from above): _________________________________ Phone: _________________

Military Branch: ____________ Rank: ___________ Status: _________ Date Retired: ____________

Employer: _____________________________ Occupation: _____________________________

Education: Last grade completed? ___________ Post-secondary education? _____________________

Continuing Education goals, if any? ____

HEALTH HISTORY

Diagnosis: ____ Date of Onset: ______________

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

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Mailing: P.O. Box 462, Nursery, TX 77976
Physical: 557 Love Road, Victoria, TX 77905
Phone/Fax: 361-578-8182
theridingtherapycenter@gmail.com
www.TheRidingTherapyCenter.org

MEDICATIONS: *(include prescriptions, over-the-counter name, dose and frequency)*

____
____
____
____
____
____

Describe any abilities/difficulties in the following areas (include assistance required or equipment needed):

PHYSICAL FUNCTION: *(i.e. mobility skills such as transfers .walking, wheelchair use driving/bus riding)*

____
____
____
____
____
____
____
____

PSYCHOSOCIAL FUNCTION: *(i.e. work/school including grade completed, leisure interests, relationships, family structure, support systems, companion animals, fears/concerns, etc.)*

____
____
____
____
____
____

GOALS: *(i.e. Why are you applying for participation? What would you like to accomplish?)*

____
____
____
____
____
____

RECOMMENDATIONS TO STAFF: *(include suggestions that you think may help or hinder progress)*

____
____
____
____
____

The information supplied above is to the best of my knowledge, up to date and accurate.

Signature: ______________________________________ Date: ____________

(Participant or Parent/Guardian/Caregiver)

Mailing: P.O. Box 462, Nursery, TX 77976
Physical: 557 Love Road, Victoria, TX 77905
Phone/Fax: 361-578-8182
theridingtherapycenter@gmail.com
www.TheRidingTherapyCenter.org

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event of an emergency and 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 THE RIDING THERAPY CENTER to:

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

Client Name: ______________________________________ DOB: ____________________

Emergency Contact: ___________________ Relation: ________________ Phone: __________

Emergency Contact: ___________________ Relation: ________________ Phone: __________

Physician's Name: ______________________________ Phone: ________________________

Preferred Medical Facility: ______________________ Allergies: __________________________

Print Name: ___________________________________
(Parent/Guardian/Caregiver)

CONSENT PLAN:

This authorization includes X-ray, surgery, hospitalization, medication and any treatment procedure deemed to be "life saving" by the physician.

Date: ____________ Consent Signature: ____
(Participant or Parent/Guardian/Caregiver)

NON-CONSENT PLAN:

I do <u>not</u> give 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 of an emergency treatment/aid is required, I wish the following procedures to take place:

____

____

Date: ____________ Consent Signature: _____________________________________
(Participant, or Parent/Guardian/Caregiver)

A copy of the completed medical history should be attached to this form.

Mailing: P.O. Box 462, Nursery, TX 77976
Physical: 557 Love Road, Victoria, TX 77905
Phone/Fax: 361-578-8182
theridingtherapycenter@gmail.com
www.TheRidingTherapyCenter.org

CONDUCT OF PARTICIPANTS AND GUESTS

It is mandatory that everyone complies with all posted safety rules and abides by all posted off-limit area. The RTC is a no smoking facility and the use of drugs or alcohol on the property will not be tolerated. No mistreatment, abuse or suggested abuse of any person or animal will be tolerated. For the safety and respect of others, no weapons of any kind are permitted on the premises.

Participants:

- Any interaction and direct contact with a horse will occur only with the permission and supervision of the Riding Instructor.
- Individuals participating in the program must conduct themselves in an appropriate manner at all times. Uncooperative, insubordinate or inappropriate behavior (including any type of harassment, aggressive or abusive behavior towards themselves, other persons or horses) may result in ineligibility and dismissal from the program.
- No one will ride under the influence of any non-prescribed drug. All riders must follow all safety procedures or they will not ride.

Guests:

- All children not involved in a program lesson MUST be supervised at all times by their parents, guardians or caregivers in a designated area away from the horses and separated from immediate lesson activities.
- All guests will be expected to comply with all safety standards. Guests who do not behave properly will be directed to leave the premises. All such incidents will be recorded and if necessary, reported to law enforcement.

Initial: __________

WARNING

Under Texas Law (Chapter 87, Civil Practice and Remedies Code) an equine professional is NOT liable for an injury to or the death of a participant in equine activities resulting from the inherent risk of equine activities.

Initial: __________

Mailing: P.O. Box 462, Nursery, TX 77976
Physical: 557 Love Road, Victoria, TX 77905
Phone/Fax: 361-578-8182
theridingtherapycenter@gmail.com
www.TheRidingTherapyCenter.org

LIABILITY RELEASE (A14):

_______________________________________, (Client's Name) would like to participate in The Riding Therapy Center's program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/my child/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 The Riding Therapy Center, its Board of Directors, Instructors, Therapists, Aids, Volunteers and/or Employees for any and all injuries and/or losses I/my child/my ward may sustain while participating in The Riding Therapy Center's program.

Signature: ____________________________________ Date: ____________
(Participant or Parent/Guardian/Caregiver)

PHOTO RELEASE (A15):

______ I hereby consent to and authorize ______ I do not consent to, nor do I authorize

…the use and reproduction of any and all photographs and other audiovisual materials, taken of me or my child or ward by The Riding Therapy Center for promotional printed or electronic materials, educational activities, exhibitions, or for any other use for the benefit of the program. No compensation will be provided for use with consent.

Signature: ____________________________________ Date: ____________
(Participant or Parent/Guardian/Caregiver)

CONFIDENTIALITY AGREEMENT (A22):

All riders, participants, volunteers and personnel at The Riding Therapy Center are to be treated with the utmost dignity and respect. This includes all interactions, as well as acknowledgement of each person's privacy. Do not give information concerning the diagnosis, treatment, or condition of any rider or participant to anyone. The status and all information concerning the riders/participants may only be discussed with the appropriate staff at The Riding Therapy Center. Do not divulge any confidential information concerning any participants, volunteers, and personnel.

By signing this document, I acknowledge the confidentiality policy of The Riding Therapy Center and by my signature, I am agreeing to comply with the confidentiality policy of all participants, volunteers and personnel.

Signature: ____________________________________ Date: ____________
(Participant or Parent/Guardian/Caregiver)

The above releases apply to all family members including parents, guardians and caregivers of this client.

Mailing: P.O. Box 462, Nursery, TX 77976
Physical: 557 Love Road, Victoria, TX 77905
Phone/Fax: 361-578-8182
theridingtherapycenter@gmail.com
www.TheRidingTherapyCenter.org

Physician Packet and Statement

Dear Healthcare Provider:

Your patient, ____ is interested in participating in supervised equine assisted activities and therapies. In order to safely provide this service, our Center requests that you complete/update the attached Medical History and Physician's Prescription/Statement Form. The following conditions suggest precautions and possible contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present and to what degree. Thank you.

Orthopedic:
Atlantoaxial Instability (AAI)
Coxas Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossifications
Joint subluxation/Dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities
Curvature of the spine 30 degrees or greater
Scoliosis
Kyphosis or Lordosis
Osteogenesis Imperfecta
Spinal Othorsis
Internal Spinal Stabilization Devices

Medical:
Severe Allergies
Cardiac Condition
Hemophilia
Migraines
PVD – Peripheral Vascular Disease
Recent Surgeries
Respiratory Compromise
Stroke (Cerebrovascular Accident)
Diabetes
Cancer
Hypertension
Varicose Veins

Neurological:
Hydrocephalus/Shunt
Seizure Disorders
Spina Bifida
Chiari II Malformation
Tethered Cord
Hydromyelia

Secondary Concerns:
Indwelling Catheters
Medications (i.e. photosensitivity)
Poor Endurance
Skin Breakdown
Acute Exacerbations of Chronic Disorder

Psychological:
Behavioral Problems
Physical, Sexual, Emotional Abuse
Dangerous to Self or Others
Animal Abuse
Fire Setting
Thought Control Disorders
Weight Control Disorders
Substance Abuse

Mailing: P.O. Box 462, Nursery, TX 77976
Physical: 557 Love Road, Victoria, TX 77905
Phone/Fax: 361-578-8182
theridingtherapycenter@gmail.com
www.TheRidingTherapyCenter.org

PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

The following pages to be completed by **Physician**

Participant Name: ____

DOB: _____________ Height: ____________ Weight: ____________ Gender: M F

Diagnosis: ___________________________________ Date of Onset: ___________

Medications: ____

Seizure Type: ______________ (NA: □) (Controlled: □ Y □ N) Date of Last Seizure: ___________

Shunt Present: □ Y □ N Date of last revision: _________ Date of Most Recent Tetanus Shot: __________

Ambulation: □ Independent □ Assisted □ Wheelchair Other Braces/Assistive Devices: ______

Head and Trunk Stability: □ Good □ Fair □ Poor

Hip Rotation: □ Good □ Fair □ Poor

Static Balance: □ Good □ Fair □ Poor

Dynamic Balance: □ Good □ Fair □ Poor

Please indicate current or past special needs in the following systems/areas, including surgeries. If none apply please check in the "No" column:

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Mailing: P.O. Box 462, Nursery, TX 77976
Physical: 557 Love Road, Victoria, TX 77905
Phone/Fax: 361-578-8182
theridingtherapycenter@gmail.com
www.TheRidingTherapyCenter.org

Prescription for Therapeutic Horseback Riding

Participant's Name: ___________________________________ DOB: ____________

Diagnosis: ____

Recommended Frequency: ____

Precautions: ____

____

Physician's Statement:

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities.

Name/Title: __________________________MD DO NP PA Other _______________

Signature: ____________________________________ Date: _______________

Address: ____

Phone: ______________________________ License/UPIN #: __________________

For Participants with Down Syndrome:

An annual medical clearance from a licensed Physician that includes a neurological exam that specifically denies any symptoms consistent with atlantoaxial instability (AAI) must be obtained prior to starting mounted activities. This medical examination including the complete neurologic exam showing no evidence of AAI and a certification from the Physician that the examination did not reveal AAI or focal neurologic disorder must be completed annually for continued participation in mounted activities.

Date of most recent annual neurologic exam: ________________

Neurological Symptoms of Atlantoaxial Instability: Present Absent

Physician's Certification that the examination did not reveal AAI, focal neurologic disorder or any signs of decrease in neurologic function:

Signed: _______________________________ **Date:** ___________________

Mailing: P.O. Box 462, Nursery, TX 77976
Physical: 557 Love Road, Victoria, TX 77905
Phone/Fax: 361-578-8182
theridingtherapycenter@gmail.com
www.TheRidingTherapyCenter.org