



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 Assisted Activities and Therapies 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.

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:

- 🕒 It is recommended that clients be at least 4 years of age and have emerging head and neck control for Therapeutic Riding.
- 🕒 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 with a \$40 administration fee 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!



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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.



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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 with a \$40 Administration Fee before you will be contacted for this screening and evaluation. Acceptance into the program is dependent upon the schedule and volunteer availability, appropriate horses for the client and safety precautions and contraindications. The RTC reserves the right to refuse or discontinue services 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. *Clients who are more than 10 minutes late for their lesson may not be allowed to ride.*

(Continued on next page)



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(Attendance and Cancellation Policy Cont.)

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.* All lesson fees are non-refundable. 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.

Client Fees and Payment:

(Please rank your top THREE preferences). The RTC will work to accommodate your preferences, however, please be advised that classes are limited due to openings in the schedule.

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

The RTC appreciates and depends on all Client Fees being paid in a timely manner.

- 🕒 All Session Fees are to be paid in full by Week One of each Session.
- 🕒 Financial Assistance is available for those who qualify.
- 🕒 Any outstanding balances must be brought current before the client can re-enroll in the next Session or participate in any extracurricular activities (i.e. horse shows, summer camps, etc.).
- 🕒 It is your responsibility to provide The RTC with updated email and/or mailing addresses for billing invoices.
- 🕒 Client Fees are made payable to The RTC by Cash, Check or Credit Card (all credit card payments will be assessed a \$3 processing fee).

Billing Information:

- Preferred billing email address. Invoices and other important notifications are emailed via secure email. _____
- I do not have an email address. Mail invoices to: _____
- I have read and agree to The RTC’s guidelines and policies, including the Attendance and Cancellation Policy included in this packet.

Signature: _____
 (Participant or Parent/Guardian/Caregiver)

Date: _____



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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: _____

Email: _____ *Please (*) your preferred method of contact for cancellations.*

Parent/Guardian/Caregiver (if applicable): _____

Address (if different from above): _____

Phone: _____ Referral Source: _____

Employer/School (of client): _____ Phone: _____

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			



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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: _____
(Participant or Parent/Guardian/Caregiver)

Date: _____



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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 not 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.



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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: _____



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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: _____
(Participant or Parent/Guardian/Caregiver)

Date: _____

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: _____
(Participant or Parent/Guardian/Caregiver)

Date: _____

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: _____
(Participant or Parent/Guardian/Caregiver)

Date: _____

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



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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

Neurological:

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

Psychological:

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

Medical:

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

Secondary Concerns:

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



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PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

The following pages are 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			



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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:** _____