

Heritage Place Equestrian
T.R.E.A.T. Riding Forms
708 Old Rutherford Road, Taylors, SC 29687
(864) 877-2583

Rider's/Parent of Rider's Complete 3 pages

Special Olympics Rider Therapeutic Rider

Starting Date _____ Ending Date _____ Time of Lesson _____ Cost of Session _____

Rider's Applications 2 Pages

Please provide all information to ensure rider's safety when T.R.E.A.T. and Heritage Place staff and volunteers are coordinating services.

Participant's Name _____ Date of Birth _____ Age _____
Height _____ Weight _____

Gender Male Female Race/Ethnicity (optional): _____

Address _____

School Name _____

Parent/Guardian Names (if applicable) _____

List Phone Numbers and relationships to rider in case of emergency:

Name _____ Relationship _____

Phone # _____ Cell # _____ Work # _____

Name _____ Relationship _____

Phone # _____ Cell # _____ Work # _____

How did you hear about our program? _____

Please describe limitations /or concerns:

Physical functions (motor skills, balance, strength)

Cognition and Processing (touch/sensation, memory, language, attention, learning disabilities)

Psychological, behavioral, emotional, or social issues

Previous riding experience

Rider's Consent & Release Form

CONSENT FOR EMERGENCY MEDICAL TREATMENT

In the event that a medical emergency occurs where medical aid/treatment is required due to illness and/or injury, while participating in the services provided or sponsored by Heritage Place Equestrian/T.R.E.A.T. or The Brookshire Family Foundation, I give my consent and authorization to said agencies to secure and retain appropriate medical treatment/ or transportation as needed. This authorization is to include any x-ray, surgery, hospitalization, and medication. In addition, I authorize said agencies to release my child/children/or ward's records to any individual involved in order to provide medical treatment/or necessary transportation.

Emergency Contact _____ Relationship _____

Phone # _____ Cell # _____ Work # _____

Physician's Name _____ Phone # _____

Health Insurance Name _____ Policy # _____

Date _____ Responsible Party Signature _____
(Parent/guardian if under 18)

Liability Release

Under South Carolina Law, an 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, under Pursuant to Article 7, Chapter 9 of Title 47, Code of Laws of South Carolina, 1976.

_____ (Rider's Name) would like to participate in Heritage Place Equestrian Center's sponsored programs. I acknowledge that I have been informed and am aware the potential for risks in riding and working with equine. However I/my child/my ward feel that the possible benefits to individuals being served are greater than the risks I have chosen to assume. I hereby am intending to be legally bound, for myself, my heirs, assigns, executors, and/or administrators, waive and release forever all claims for damages against Heritage Place Equestrian, The Brookshire Family Foundation, its Board of Directors, Advisory Board, Instructors, Therapist, volunteers, agents, and representative of any kind for any an all injuries, damages, claims, demands, causes of actions, law suits, and/or losses I/my child/my ward may sustain while participating in any said program sponsored or held by Heritage Place Equestrian or The Brookshire Family Foundation.

Date _____ Responsible Party Signature _____
(Parent/guardian if under 18)

Photo Release

I hereby consent to and authorize the use and reproduction by Heritage Place Equestrian Center and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional printed material, educational activities, exhibitions, or for any other beneficial use to the program.

Date _____ Responsible Party Signature _____
(Parent/guardian if under 18)

Guardian/Participant Clause

I understand that the treatment team of T.R.E.A.T. will weigh all medical information and reserves the right to deny services at anytime if the participant's mental or physical well being is in jeopardy.

Date _____ Responsible Party Signature _____
(Parent/guardian if under 18)

Riding Lesson Contracts
NON T.R.E.A.T. RIDER LESSON FORMS

I (Parent/Guardian), _____ have given my permission to Heritage Place Equestrian/ T.R.E.A.T. to administer riding lessons to _____.

I will agree to inform the Executive Director of Heritage Place or the Head Riding Instructor of any medical changes in myself or my child/children that might affect my performance during my riding lesson (grounded/mounted).

I understand that my riding lessons are to be paid for two weeks in advance unless other arrangements have been made with the Executive Director. No refunds or make up lessons will be given if a rider is dismissed due to behavior or compliance issues. If for a medical reason a rider must miss or discontinue riding lessons a written Doctors note must be provided before a refund is considered.

Make-up lessons will be provided in the case of medical issue (Doctors Note required), death in the family, or the lesson was cancelled by Heritage Place/T.R.E.A.T. or its agents due to inclement weather or scheduling conflicts.

I understand that my riding lessons are scheduled and that it is important that I arrive on time. If I/my child are more than 15 minuets late for a scheduled lesson it is to be understood that the horse will be placed back into its pasture/stall and that my lesson will be cancelled. I also, understand that I will be charged for this lesson if I have not given at least a 6 hour notice.

I understand that proper riding attire must be worn meaning long pants, shirt, appropriate footwear, and during mounted riding lesson a SEI-ASTM approved riding helmet must be worn regardless of age or experience.

I also agree to follow all barn rules and regulations given to me in the Heritage Place Equestrian/T.R.E.A.T. Policies and Rulebook. I agree that if any instructor, volunteer, or agent of Heritage Place Equestrian/T.R.E.A.T., or other therapeutic agent of these institutions has the right to discipline a rider verbally if that rider has become disruptive, disrespectful, or is endangering his/her life or the lives of others. If the rider continues to be disruptive the rider (and rider's family if under 18) will need to speak to the Executive Director. If a third incident occurs the rider will be asked to leave the program and will not receive a refund.

Sign if you have received and have read Heritage Place Equestrian/T.R.E.A.T. Policies and Rulebook.

ACCEPTED BY:
SIGNATURE _____ (RIDER)

SIGNATURE _____ (OF GUARDIAN)

WITNESS _____

Participant's Medical History & Physician Statement

(Must Have Been Completed By Medical Professional)

Participant's Name _____ Date of Birth _____
 Address _____ Home phone _____
 Names of Parent(s)/Guardian(s) _____
 Height _____ Weight _____

Medications/Herbal Supplements _____

Mobility:

Independent Ambulation or Assisted Ambulation: Braces Crutches Walker Wheelchair

Special Precautions:

Seizure: Yes No

Seizure Type _____ Date of Last Seizure _____ Controlled? Yes No

Shunt: Yes No Date of last Revision _____

Down Syndrome: Atlanto Dens Interval X-rays, date _____ Result + --

Any Neurological Symptoms of Atlanto Axil Instability? _____

Primary Diagnosis/Presenting Concerns _____

Secondary Diagnosis/Presenting Concerns _____

Please list current or past indications/special needs in the following spaces

Areas	Yes	No	Comments
Pain			
Neurological			
Speech & language			
Cognitive/processing			
Learning & development			
Muscular			
Auditory			
Visual			
Psychological/Emotional/			
Behavioral			
Balance			
Cardiac			
Circulatory			
Pulmonary			
Integumentary/Skin			
Allergies			
Orthopedic-Note Scoliosis or Hip/Joint Issues			

To my professional knowledge, there is no reason that this person cannot participate in supervised equestrian activities, I concur with a review of this person's abilities and have considered his limitations and by a licensed/credentialed health professional, as necessary, in the implementation of effective equine activity programs.

Date _____ Name & Title (print) _____

Signature _____ Phone # _____

Address _____

Dear Health Care Provider:

Your patient is interested in participating in supervised equine activities. We have provided you with a short description of our services so you can see how your patient may benefit from our services. In order for our team of professionals to provide safe services, we request the following information be completed and returned with the attached PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN STATEMENT. Please note that the following listed conditions may suggest that more safeguards be put in place while the participant/rider is involved in our services. Please note whether these conditions are present and to what degree.

ORTHOPEDIC

Atlantoaxial instability – include neurological symptoms
Cranial Defects
Joint Subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/ Abnormalities

NEUROLOGIC

Hydrocephalus/Shunt
Spinal Bifida
Seizures
Autism

MEDICAL/PSYCHOLOGICAL

Allergies
Physical/Sexual Abuse
Dangerous to self or others
Fire setting
Animal Abuse
Hemophilia
Poor Endurance
Recent Surgeries
Medical Instabilities

PVD
Migraines
Blood pressure
Fatigue
Medications
Heart Conditions
Respiratory Compromise

Thank you for your assistance. If you have any further concerns about your patients involvement in our equine activities please contact me at (864) 877-2583.

Lu Grant
Executive Director