DREAM RIDERS

156 Sandy Hill Rd. Lexington, SC 29072 **EIN # 57-1079606**
Phone (803) 957-7906 **emaildreamr2@mindspring.com**
Web page: www.dreamrider.org

To Whom It May Concern,

Dream Riders is a therapeutic horseback riding program for people with physical and mental disabilities. Each approved applicant is evaluated and annual goals are developed for the individual rider.

Before an applicant can be considered for inclusion in the Dream Riders program the attached forms must be completely filled out and returned to Dream Riders.

- New and present riders must meet the Dream Riders' age and weight policy as stated on **Page 2**
- Physician's cover letter and medical history & physician's statement must be completely filled out and signed by the applicant's physician. It must be the original form no faxed or copied forms will be accepted. **Pages 3 & 4**
- Participant's Authorization for Emergency Medical Treatment to be completed, signatures of client, parent, or guardian to be done in the presence of Dream Riders staff just prior to pre-assessment. **Page 5**
- Participant's Application and Health History to be completed, signatures of client, parent, or guardian to be done in the presence of Dream Riders staff just prior to pre-assessment. **Pages 6 & 7**

Once all forms are received at Dream Riders and are verified for completeness, if the applicant is an appropriate candidate for therapeutic riding according to the PATH Intl. guidelines, the applicant will be put on the waiting list to be pre-assessed.

A pre-assessment of all new applicants will be done prior to acceptance into the Dream Riders program. After being accepted into the program, a riding contract will be issued to the rider to be completed and returned to Dream Riders with the session fee prior to session starting, unless other arrangements have been agreed too.

Dream Riders offers morning sessions and afternoon/evening sessions. There are four sessions a year with each session being 6 weeks long. The cost of these sessions is $120.00. There is one summer session a year being 4 weeks long. The cost of the summer session is $80.00.
Forms can be copied and distributed as needed.

We thank you for your interest and hope to hear from you soon; any questions please contact us at (803) 957-7906 or email dreamr2@mindspring.com

Sincerely

Jennifer Stoudemire

Jennifer Stoudemire, Dream Riders' Head Riding Instructor

PREMIER ACCREDITED CENTER
PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

updated 2018

Dream Riders' Rider Policies

Please note that horseback riding is contraindicated for some conditions/ individuals. As a PATH Intl. (Professional Association of Therapeutic Horsemanship International) Premier Accredited program, we must follow PATH Intl. guidelines for physical restrictions of riding. Refer to the PATH Intl. Precaution and Contraindication Guide (located in Dream Riders' office) for detailed information. Dream Riders reserves the right to deny services to any individual based upon concerns for the applicant's safety and/ or the safety of the volunteers, staff, property owners, horses, or for other reasons in accordance with PATH Intl. operating center guidelines. Final determination for participation will be made by the instructors at Dream Riders.

Dream Riders offers Equine Assisted Activities of therapeutic horsemanship and therapeutic riding in a group lesson setting. Defined by PATH Intl. Therapeutic Horsemanship is equine activities organized and taught by a Professional Association of Therapeutic Horsemanship International Certified Instructor specifically trained to work with people with disabilities or diverse needs. The intent is for students to progress in equestrian skills while improving their cognitive, emotional, social and/or behavioral skills. Therapeutic Riding is therapeutic horsemanship that involves mounted activities including traditional riding disciplines or adaptive riding activities. It is a Dream Riders policy that riders demonstrate basic equestrian/ riding skills within a year of being accepted into the lesson program.

Age Policy

Minimum Age: 4 years old for therapeutic riding lessons.
Maximum Age: There is not a maximum age. The only requirement is that the person is able to physically and safely perform what is required in a therapeutic riding lesson.

Weight Policy

According to PATH Intl. guidelines, riding is contraindicated:

- If the staff is unable to safely manage the participant in any situation, including an emergency dismount, and is at risk for harming themselves or the participant
- If safety or comfort of the equine is compromised during mounted activities potentially resulting in a fight or flight response, which in turn could harm the staff or participant

Weight considerations for all riders: Maximum weights are listed below, but decisions regarding participation will be based on the availability of a suitable horse relative to the height, weight, cognition, and balance of the participant. Dream Riders reserves the right to weigh all participants at any time. If the rider has surpassed the weight limit during the session they will no longer be able to participate in the lessons. Riders who surpass the weight limit during the session will not receive a refund for remaining lessons.

Dream Riders Height and Weight Table (maximum weight is with clothing on)

Height	Maximum Weight
4' and under	120 lbs
4'1"-5 '	150 lbs
5'1" to 5'6"	175 lbs
Above 5'7"	180 lbs

*It is Dream Riders policy that riders have enough head and trunk control to balance while sitting on a horse independently by holding on to the therapy surcingle requiring minimal to no physical assistance. They must be able to assist in transfer on and off of the horse. Applicants who are unable to sit unassisted may require direct treatment by a therapist in a hippo therapy program, which is not offered at Dream Riders.

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Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____
Address: _____
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: Neurologic Symptoms of Atlantoaxial Instability: _____ Present _____ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	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 and/or therapies. 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 Intl. Center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: (___) _____ License/UPIN Number: _____

DREAM RIDERS

156 Sandy Hill Rd., Lexington, SC 29072 **Phone (803) 957-7906**

Date: _____

Dear Health Care Provider:
Your patient _____
(participant's name)

is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the Medical History and Physician's Statement Form on the reverse side. 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
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia

Other

Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - e.g., Photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (e.g., RA, MS)
Fire Setting
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 patient's participation in equine-assisted activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,

Jennifer Henderson

Dream Riders
Head Riding Instructor

DREAM RIDERS

Participant's Authorization
For
Emergency Medical Treatment Form

Name: _____ DOB: _____ Phone: _____
Address: _____
Physician's Name: _____ Preferred Medical Facility: _____
Health Insurance Company: _____Policy # _____
Allergies to medications: _____
Current medications: _____
Caregivers: _____
Address (if different from above): _____
Phone: _____

In the event of an emergency contact:
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____Phone:_____
Name: _____ Relation: _____Phone: _____

Consent Plan
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 DREAM RIDERS to:

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

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(s) above is unable to be reached

Date: _____ Consent Signature: _____
Client, Parent or Legal Guardian

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.

O Parent or legal guardian will remain on site at all times during equine-assisted activities.

O In the event emergency treatment/aid is required, I wish the following procedure to take place:
_____
_____
_____

Date: _____ Non-Consent Signature: _____
Client, Parent or Legal Guardian

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Participant's Application & Health History

GENERAL INFORMATION

Participant:_____
DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F
Address: _____
Phone: _____ Email: _____ Alternative #: _____
Employer/School:_____
Address:_____
Phone:_____
Parent/Legal Guardian:_____
Caregivers:_____
Address(if different from above):_____
Phone:_____
Referral Source: _____
Phone:_____
How did you hear about the program? _____

HEALTH HISTORY

Diagnosis: _____ Date of Onset: _____

Please indicate current or past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

MEDICATIONS (include prescription and over-the-counter, name, dose and frequency) _____
_____
_____
_____
_____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):
PHYSICAL FUNCTION (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding)
_____
_____
_____
_____
_____
_____

PSYCHOSOCIAL FUNCTION (e.g., work/school including grade completed, leisure interests, relationshipsfamily structure, support systems, companion animals, fears/concerns, etc.)
_____
_____
_____
_____
_____
_____

GOALS (i.e., why are you applying for participation? What would you like to accomplish?
_____
_____
_____
_____

Signature _____ Date _____

PHOTO RELEASE

I ❑ DO

❑ DO NOT

consent to and authorize the use and reproduction by Dream Rider of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Client, Parent or Legal Guardian
Signed in the presence of center staff

Liability Release at Dream Riders:

Under South Carolina Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of equine activity, Pursuant to Article 7, Chapter 9 of Title 47, Code of Laws of South Carolina, 1976.

I acknowledge the risks and potential for risks of equine activities and horseback riding. I further understand that I must be careful while on the property of Dream Riders. Dream Riders cannot and does not assume any liability for accidents, injury, or death to person or persons. However, I feel that the possible benefits to myself/ my son or daughter/ my ward are greater than the risk assumed. I further have reviewed and understand the content of South Carolina's Liability Law which is posted at drive entrance, barn and bathroom area. Likewise I accept full responsibility for friends and visitors accompanying myself on Dream Riders property. 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 Dream Riders, Sunrise Farms, its board of directors, instructors, volunteers, and/or employees for any and all injuries and/or losses I/ my son or daughter/ my ward may sustain while participating in activities at Dream Riders.

Signature: _____ Date: _____

Client, Parent or Legal Guardian
Signed in the presence of center staff