

# DREAM



# RIDERS

156 Sandy Hill Rd. Lexington, SC 29072

Phone (803) 957-7906

EIN # 57-1079606

emaildreamr2@mindspring.com

Web page: [www.dreamrider.org](http://www.dreamrider.org)

To Whom It May Concern,

Dream Riders is a therapeutic horseback riding program for people with physical and mental disabilities of all ages. The program is set up to teach riders complete horsemanship. Each approved applicant is evaluated and annual goals are developed for each 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 attached sheet. **Page 2**
- Physician's cover letter and medical history & physician's statement must be completely filled out and signed by the applicant's physician. **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 NARHA guidelines, the applicant will be put on the waiting list if there is not an available riding lesson slot.

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 day sessions and afternoon sessions. There are four day sessions a year with each session being 6 weeks long. The cost of the day session is \$120.00. There are six afternoon sessions a year each session being 5 weeks long. The cost of the afternoon session is \$100.00.

**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.

Sincerely

Jennifer Stoudemire, Dream Riders' Head Riding Instructor

File: riders material/rider packet

## Dream Riders Age and Weight Policies

Unfortunately, riding is not an appropriate activity for everybody and we occasionally have to decline services to those to whom riding is contraindicated. As a NARHA (North American Riding for the Handicapped Association) Premier Accredited program, we must follow NARHA guidelines. To be in compliance with NARHA national standards, we have established the following:

### 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 NARHA guidelines, riding is contraindicated:

1. If the staff is unable to safely manage the participant in any situation, including an emergency dismount.
2. If safety or comfort of the horse is compromised during mounted activities.

The chart below shows the maximum weight per height that is appropriate for riding at Dream Riders. People within the limit will be evaluated by staff to determine if riding is a safe and appropriate activity.

### Dream Riders Height and Weight Table

<i>Women and Girls</i>	<b>Maximum Weight</b>	<i>Men and Boys</i>	<b>Maximum Weight</b>
<b>Height</b>		<b>Height</b>	
4' and under	110 pounds	4' and under	115 pounds
4'1"-4'6"	125 pounds	4'1"-4'6"	130 pounds
4'7"-4'10"	140 pounds	4'7"-4'10"	145 pounds
4'11"-5'	154 pounds	4'11"-5'	170 pounds
5'1"-5'2"	159 pounds	5'1"-5'2"	175 pounds
5'3"-5'4"	167 pounds	5'3"-5'4"	180 pounds
5'5"-5'6"	173 pounds	5'5"-5'6"	185 pounds
5'7"-5'8"	181 pounds	5'7"-5'8"	190 pounds
5'9"-5'11"	186 pounds	5'9"-5'11"	195 pounds
6' and above	200 pounds	6' and above	200 pounds

# 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 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 Fusion/Fixation  
Spinal Instability/Abnormalities

## **Neurologic**

Hydrocephalus/Shunt  
Seizure  
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

## **Other**

Age - under 4 years  
Indwelling Catheters  
Medications - i.e. photosensitivity  
Poor Endurance  
Skin Breakdown

## **Medical/Psychological**

Allergies  
Animal Abuse  
Physical/Sexual/Emotional Abuse  
Blood Pressure Control  
Dangerous to self or others  
Exacerbations of medical conditions  
Fire Settings  
Heart Conditions  
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 activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,



# DREAM RIDERS

## 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: AtlantoDens Interval X-rays, date: \_\_\_\_\_ Result: + --  
 Neurologic Symptoms of AtlantoAxial Instability: \_\_\_\_\_

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

	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			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the NARHA center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Name/Title: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: (     ) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_

# 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: \_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

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 \_\_\_\_\_ to:  
(Center's Name)

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.

### Consent Plan

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  
*Signed in presence of center staff*

### 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: \_\_\_\_\_ Consent Signature: \_\_\_\_\_

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

**A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM.**



# DREAM RIDERS

## Participant's Application and Health History

### GENERAL INFORMATION

Participant: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: M F

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternative #: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_

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			

(over)

**MEDICATIONS** (include prescription, over-the-counter; name, dose and frequency) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Describe your 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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PSYCHO/SOCIAL 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?)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PHOTO RELEASE**

- I  DO  
 DO NOT

consent to and authorize the use and reproduction by \_\_\_\_\_  
(center) 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:**

I acknowledge the risks and potential for risks of an equine activity. However, I feel that the possible benefits to myself/ my son or 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 for ever all claims and damages against Dream Riders, its Board of Directors, Instructors, Aides, Volunteers and / or Employees for any and all injuries and / or losses i/ my son or daughter/ my ward may sustain while participating in Dream Riders.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_