



**North Carolina Therapeutic Riding Center**

P.O. Box 841, Carrboro, N.C. 27510

919-304-1009 [www.nctrcriders.org](http://www.nctrcriders.org)



Dear Prospective NCTRC Participant:

Thank you for your interest in the North Carolina Therapeutic Riding Center (NCTRC). Enclosed, you will find a Participant Application Form, a Participant Consent and Release Form, a Physician/Medical Statement form (includes a letter to your physician), and a Rider Information Form. The first step toward participating in a NCTRC session is to complete and return these forms. The application and rider information forms are for you to complete, and your physician completes the Medical form. The forms can be mailed to the above address. Once we have received **ALL** forms, we will contact you to schedule an evaluation. The cost of the evaluation is \$45 dollars.

During the evaluation, we will ensure that our program is appropriate for you and that there are no contraindications to you or your child's participation. We will discuss our services to determine how we can best meet your needs. We will also conduct a brief evaluation on the horse. Please come to your evaluation dressed to ride (long pants and closed toe shoes). Riding helmets are provided for all riders. Following the evaluation and the determination that we can safely accommodate you, you will be eligible to register for our upcoming riding session.

We strive to provide the safest possible conditions for participants, volunteers, and employees. NCTRC is a Premiere Accredited Center, and we adhere to all precautions and contraindications established by NARHA. The acceptance, and continued participation of a rider, in our program depends on the availability of instructors, volunteers, and suitable horses. NCTRC retains the right to refuse any participant that we cannot safely accommodate. Participants must inform us of changes in health status. NCTRC requires annual updates of the Medical History Form in addition to updates needed following changes in health status, hospitalization, and surgery.

Thanks again for your interest in our program. We look forward to meeting you.

Sincerely,

*Lorraine O'Keefe*

NCTRC Program Director

*Joey Reed'*

NCTRC Administrative Coordinator



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## PARTICIPANT APPLICATION

In order to ensure coordinated care, NCTRC staff and volunteers are provided with information about participant's abilities/disabilities.

Participant's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Male  Female  Race/Ethnicity \_\_\_\_\_ (optional)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

School Name \_\_\_\_\_

Parent or Guardian Name(s) \_\_\_\_\_

Rider or Guardian Employer \_\_\_\_\_

List Phone Numbers and whose number it is, if other than Participant:

Home \_\_\_\_\_ Name (if not participant) \_\_\_\_\_

Work \_\_\_\_\_ Name (if not participant) \_\_\_\_\_

Cell \_\_\_\_\_ Name (if not participant) \_\_\_\_\_

Email \_\_\_\_\_ Participant or Caregiver (circle one)

How did you hear of our program? \_\_\_\_\_

### Please describe limitations/concerns in these areas:

Physical function (e.g. ambulation, motor skills, balance, strength, tone, vision):

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Cognition and Processing (e.g. attention, touch/sensation, memory, speech and language, sensory integration, learning disabilities, developmental delays):

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Psychological, emotional, behavioral, social issues:

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Do you have previous riding experience? If so, please describe: \_\_\_\_\_

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### PARTICIPANT'S CONSENT & RELEASE FORM

#### CONSENT FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury while participating in the service of, or while being on the property of the North Carolina Therapeutic Riding Center (NCTRC), I authorize NCTRC to secure and retain medical treatment and/or transportation if needed. This authorization includes but is not limited to x-ray, surgery, hospitalization and medication. In addition, I authorize NCTRC to release my/my child's/my ward's records to any individual involved in medical treatment and/or necessary transportation.

Participant's Name \_\_\_\_\_

In case of emergency: 1<sup>st</sup> contact \_\_\_\_\_ Phone \_\_\_\_\_

2<sup>nd</sup> contact \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Preferred Facility \_\_\_\_\_

Date \_\_\_\_\_ Participant Signature \_\_\_\_\_

(or signature of parent/guardian if participant is under age 18 yrs.)

**Non-Consent Plan:** I do not give my consent for emergency medical treatment/aid, in the case of illness or injury while participating in activities with the North Carolina Therapeutic Riding Center. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Non-Consent Signature \_\_\_\_\_ Date \_\_\_\_\_

(or signature of parent/guardian if participant is under 18 yrs.)

#### Photo Release (Check one)

I hereby consent to and authorize the use and reproduction by the North Carolina Therapeutic Riding Center of any and all photographs and any other audiovisual materials taken of me/my child/ my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

I do not consent to the above use of photo or videographic materials.

Date \_\_\_\_\_ Participant Signature \_\_\_\_\_

(or signature of parent/guardian if participant is under age 18 yrs.)

**LIABILITY RELEASE: Under Chapter 99E of the North Carolina General Statutes, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting exclusively from the inherent risks of equine activities.**

Whereas, \_\_\_\_\_ (Participant's name) would like to participate in the North Carolina Therapeutic Riding Center (NCTRC) equestrian programming conducted at Clearwind Farm in Mebane, NC and hereby acknowledges his or her understanding of the inherent risks involved in riding and working around horses, which risks include bodily injury, disability or death from accidents incurred while using, riding, or being proximate to horses; and further acknowledges that both horse, rider and volunteers assisting with therapeutic riding classes can be injured in normal use or in competition and schooling;

**Now Therefore,** in exchange for the opportunity to participate in therapeutic programming conducted by the Riding Center, the Undersigned does hereby release and forever discharge the Riding Center and Clearwind Farm, their owners, employees, volunteers, heirs, successors, assigns, and personal representatives from any and all actions, causes of action, claims, demands, damages, charges and expenses, including court costs and counsel fees, and against all loss and damages whatever, for upon or by reason of any personal property loss, personal injury, disability or death which may result from any activity or involvement that the Undersigned engage in through the Riding Center.

**I DO EXPRESSLY CONSENT TO ASSUME ANY RISK, CHANCE OF HARM, PERSONAL OR REAL PROPERTY DAMAGE, INJURY, SUFFERING, DISABILITY OR DEATH INVOLVED WITH OR RESULTING FROM MY PARTICIPATION IN PROGRAMS CONDUCTED BY THE RIDING CENTER.**

Date \_\_\_\_\_ Participant Signature \_\_\_\_\_

(or signature of parent/guardian if participant is under age 18 yrs.)



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### Dear Health Care Provider:

Your patient is interested in participating in supervised equine activities. In order to safely provide this service, we request that you complete (or update) the attached Medical History. 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

#### Medical/Psychological

Allergies  
Animal Abuse  
Physical/Sexual/Emotional Abuse  
Blood Pressure Control  
Dangerous to self or others  
Exacerbations of medical conditions  
Fire Setting  
Heart Condition  
Hemophilia  
Medical Instability  
Medications – e.g. photosensitivity  
Migraine  
PVD  
Poor Endurance  
Respiratory Compromise  
Recent Surgeries  
Recent Surgeries  
Skin Breakdown  
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 contact me at 919-304-1009.

Sincerely,

*Lorraine O'Keefe*

Program Director



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## MEDICAL HISTORY & PHYSICIAN STATEMENT

To be completed by physician

Participant's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Home Phone# \_\_\_\_\_

Name of Parent(s)/Guardian(s) \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Medications \_\_\_\_\_

**Mobility:** Independent Ambulation  **OR** Assisted Ambulation: Braces  Crutches  Walker  Wheelchair

**Special Precautions:** Shunt: Yes  No  Date of Last Revision \_\_\_\_\_

Seizures: Yes  No  Seizure Type \_\_\_\_\_ Date of Last Seizure \_\_\_\_\_ Now Controlled? Yes  No

Down Syndrome: Atlanto Dens Interval X-rays, Date \_\_\_\_\_ Result: (circle) + -

Any Neurologic Symptoms of Atlanto Axial Instability? \_\_\_\_\_

**Primary** Diagnosis/Presenting Concern \_\_\_\_\_ Date Onset \_\_\_\_\_

**Secondary** Diagnosis/Presenting Concern \_\_\_\_\_

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

AREAS	YES	NO	COMMENTS
Visual			
Auditory			
Tactile Sensation			
Speech & Language			
Cognitive/Processing			
Learning & Development			
Psychological/Emotional/Behavioral			
Muscular			
Balance			
Orthopaedic-Note Scoliosis or Hip Subluxation/Dislocation			
Neurologic			
Cardiac			
Circulatory			
Pulmonary			
Integumentary/Skin			
Immunity			
Pain			
Allergies			
Other			

To my knowledge, there is no reason this person cannot participate in supervised equestrian activities. I concur with the referral of the patient to a licensed/credentialed therapist or health professional, as necessary, for evaluation of abilities/limitations in performing exercises and in the implementation of an effective equine activity program.

Date \_\_\_\_\_ Name & Title (print) \_\_\_\_\_ MD DO NP PA

Signature \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_



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## **Rider Information and Health History Questionnaire (Two Pages)**

NCTRC would like to know more about our riders in order to serve them best. For example, what is motivating, what is helpful, what could be safety concerns? Thank you for completing this questionnaire.

Rider's Name \_\_\_\_\_

Date \_\_\_\_\_

*Describe abilities and needs or difficulties in each of the areas below. The words in parentheses are only suggested things to consider.*

### **1. Communication** (ability to understand, to express wants and needs, to communicate with peers socially)

If there are needs in this area, what strategies are currently being used and which are most beneficial? (picture schedule, signing etc.)

### **2. Learning Style** (attention, following directions, abstract concepts, reading ability)

If there are needs in this area, what approaches are currently most helpful?

### **3. Personality and Behavior** (confident, shy, easy going, anxious, fearful, impulsive, aggressive)

What things are most motivating?

If there are significant needs, what strategies are helping?



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**Rider Information and Health History Questionnaire (Continued)**

**4. Physical Abilities and Needs** (balance, strength, coordination, gross and fine motor skills, loss of sensation or hypersensitivities)

What adaptations are currently needed or helpful?

**5. Medical needs that we should be aware of** (breathing concerns, any seizures, allergies, recent surgeries)

**Current Medications and Care Plans:**

**6. What therapy is being received?**

**7. Goals:** What are the most important areas for change?

What would you like to see addressed in therapeutic riding activities?

Person Completing Questionnaire \_\_\_\_\_

Relationship to Rider \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_