



North Carolina Therapeutic Riding Center
P.O.Box 841 Carrboro, N.C. 27510
www.nctrcriders.org 919-304-1009

CAMPER INFORMATION SHEET 2009

Please complete this form for your child, so NCTRC's staff and volunteers can get to know each camper before the first day of camp.

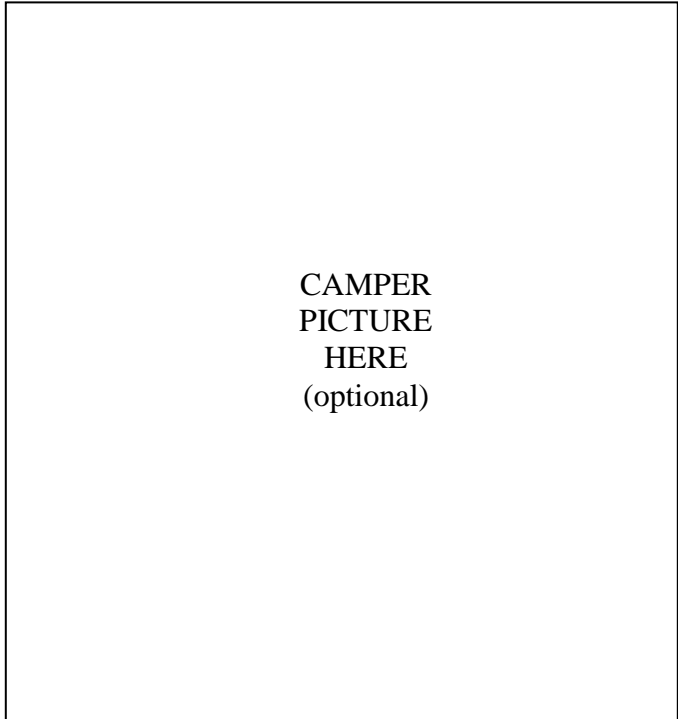
NAME: _____

AGE: _____ BIRTHDATE: _____

Please Circle One or Both:

All Abilities Camp I
August 3 – 7

All Abilities Camp II
August 10 - 14



CAMPER
PICTURE
HERE
(optional)

Please Answer the Following Questions.

Elaborate on back of sheet if needed.

- 1) Have you ever ridden at NCTRC (when)? _____
- 2) Please let us know about previous riding experience you may have _____
- 3) Does Camper have any special needs? _____
- 4) Does camper have mobility impairments? _____
- 5) Please note if camper needs one on one assistance with personal care, an attendant must accompany him/her at camp: Yes / No Name and Phone # of Attendant _____
- 6) Friends or Siblings also attending camp: _____
- 7) Interest and Hobbies _____
- 8) What is camper especially looking forward to doing at camp? _____

Is there anything we haven't asked that you would like to let us know? (Please add an extra sheet if needed.)



North Carolina Therapeutic Riding Center
 P.O. Box 841, Carrboro, NC 27510
 919-304-1009 www.nctrcriders.org



PARTICIPANT APPLICATION (TWO SIDES)

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):

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

Psychological, emotional, behavioral, social issues:

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



North Carolina Therapeutic Riding Center
 P.O. Box 841, Carrboro, NC 27510
 919-304-1009 www.nctrcriders.org



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: 1st contact _____ Phone _____

2nd 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 PROERTY 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.)



North Carolina Therapeutic Riding Center

P.O. Box 841, Carrboro, NC 27510

919-304-1009 www.nctrcriders.org



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.

Orthopaedic

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
Migraine
PVD
Poor Endurance
Respiratory Compromise
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



North Carolina Therapeutic Riding Center
 P.O. Box 841, Carrboro, NC 27510
 919-304-1009 www.nctrcriders.org



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** _____