Graz'n Acres Therapeutic Riding Center
14492 Ivor Road
Sedley, VA 23878
Office: (757) 653-9615 Fax: (757) 653-0219
Email: craiford@graznacres.org
www.graznacres.org

Date: ______________

Your patient, ________________________ is interested in participating in supervised equestrian activities. In order to safely provide this service, our therapeutic riding center requests that you complete below and the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing the 2nd page, please note whether these conditions are present and to what degree.

Orthopedic
Atlantoaxial Instability
Coxa Arthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint Subluxation/dislocation
Osteoporosis
Pathological Fractures
Scoliosis / Lordosis / Kyphosis
Spinal Fusion/Fixation/Orthoses
Spinal Instability/Abnormalities

Neurological
Hydrocephalus/Shunt
Paralysis due to Spinal Cord Injury
Hydrocephalus/Shunt
Seizure Disorder
Spina Bifida/Chiari II Malformation
Tethered Cord/Hydromyelia

Other
Age – less than 4 years
Indwelling catheters
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Abuse - Physical/Sexual/Emotional
Behavior Problems
Blood pressure control
Cancer
Dangerous to self or others
Diabetes
Exacerbation of medical condition
Fire Settings
Heart Condition / Hypertension
Hemophilia
Medical Instability
Migraines
Peripheral Vascular Disease (PVD)
Respiratory Compromise
Recent Surgeries
Stroke (Cerebrovascular Accident)
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 therapeutic equine activities, please feel free to contact the center at the address/phone indicated above.

Cyndi Raiford

Cyndi Raiford
Director / Lead Instructor

Participant's Medical History and Physician's Statement

Participant: ______________________ DOB: ________ Height: ________ Weight: ________

Address: ______________________ Age: ____________

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: ______________________

Tetanus Shot: Y N Date: ___ ________

DOWN SYNDROME Diagnosis: Neurological Symptoms of Atlantoaxial Instability: ______Present _____Absent

AtlantoDens Interval X-Ray: Date: ____________ Result: Pos. Neg.

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

Areas	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
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. I understand that the PATH Intl. center will weigh 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: ______________________

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ADULT RIDER RELEASE AGREEMENT

I/We, the undersigned, for and in consideration of the agreement of the **Graz'n Acres Therapeutic Riding Center**, to provide therapeutic riding or driving instruction to said person, do/does hereby forever release, acquit, discharge, and hold harmless the **Graz'n Acres Therapeutic Riding Center, and Graz'n Acres Farm**, its officers, trustees, agents, owners, employees, representatives, successors, and assigns, for all manner of claims, demands, and damages of every kind and nature whatsoever, which the undersigned may now or in the future have against **Graz'n Acres Therapeutic Riding Center, and Graz'n Acres Farm**, its officers, trustees, agents, owners, employees, representatives, successors, or assigns on account of any personal injuries, physical or mental condition, known or unknown, to the person, and the treatment thereof, as a result of, or in any way growing out of the acts of the **Graz'n Acres Therapeutic Riding Center, and Graz'n Acres Farm**, its officers, trustees, agents, owners, employees, representatives, successors, or assigns, including but not limited to their negligence or gross negligence, in rendering the services above described or in any way incidental thereto.

I acknowledge and understand the risks and potential risks of horseback riding including, but not limited to: 1) The propensity of an equine to behave in dangerous ways which may result in injury or death to the participant or damage to property; 2) The inability to predict an equine's reaction to sound, movements, objects, persons or animals; 3) Hazards of surface or subsurface conditions whether known or unknown. However, I feel the possible benefits to myself are greater than the risks assumed.

Dated this _______ day of ____________, 20 ____.

____
NAME (Please Print)

____
SIGNATURE

(02/12)

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STUDENT PHOTOGRAPH RELEASE FORM

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to the **Graz'n Acres Therapeutic Riding Center** permission to take or have taken still and moving photographs and films, including but not limited to television pictures of myself or our/my (son/daughter/ward) ____,
and consents and authorizes the **Graz'n Acres Therapeutic Riding Center** and its advertising agencies, news media, and any other persons interested in the **Graz'n Acres Therapeutic Riding Center** and its work to use and reproduce the photographs, films and pictures and to circulate and publicize the same by all means including without limiting the generality of the foregoing newspapers, television media, brochures, pamphlets, instructional materials, books and/or clinical materials.

With respect to the foregoing matters, no inducements or promises have been made to us/me to secure our/my signature(s) to this release other than the intention of the **Graz'n Acres Therapeutic Riding Center** to use or cause to be used such photographs, films and pictures for the primary purpose of promoting the **Graz'n Acres Therapeutic Riding Center** and its work**.**

Dated this _______ day of ____________, 20 ____.

____

PARTICIPANT / PARENT / GUARDIAN

NON-CONSENT FOR PHOTOGRAPHS

For reasons that I am not obligated to disclose, **I DO NOT GIVE CONSENT** for photographs, either still or moving, or any television or news media, to be taken of myself or our/my (son/daughter/ward) ____, by the **Graz'n Acres Therapeutic Riding Center** or any persons working on behalf of said center. I understand that a **RED DOT** will be placed on the record kept in the administrative offices of the center which will designate the photographs are not allowed of said person.

Dated this _______ day of ____________, 20 ____.

____

PARTICIPANT / PARENT / GUARDIAN

(02/12)

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Participant's Consent for Release of Information

I hereby authorize ____
(person or facility)

To release information from the records of: ______________________ DOB: ________
(participant's name)

The information is to be released to: ***Graz'n Acres Therapeutic Riding Center***

For the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

☐ Medical History

☐ Physical therapy evaluation, assessment and program plan

☐ Speech therapy evaluation, assessment and program plan

☐ Mental Health diagnosis and treatment plan

☐ Individual Habilitation Plan (IHP)

☐ Classroom Individual Education Plan (IEP)

☐ Psychosocial evaluation, assessment and program plan

☐ Cognitive-behavioral management plan

☐ Other: ____

This release is valid for one year and can be revoked, in writing, at my request.

Signature: ______________________________ Date: ____________

Print Name: ______________________________
Relation to Participant: ______________________________

Please fax or send materials to above address.

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

☐ Participant

Name: ______________________________ DOB: ____________ Age: _____

Address: ____

Phone: ______________ Email: ______________________________

Physician: ______________________________ Phone: ______________

Medical Facility: ____

Health Insurance Co.: ____________________ Policy Number: ______________

Allergies to medications: ____

Current Medications (include over the counter): ______________________________

____

Allergies: ____

In the event of an emergency, contact:

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, assisting the center, or while being on the property of the center, I authorize the Graz'n Acres Therapeutic Riding Center 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.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. The provision will only be invoked of the person below is unable to be reached.

Date: ____________ Consent Signature: ______________________________

Participant (if over the age of 18), Parent or 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 center. In the event emergency treatment/aid is required, I wish the following procedure to take place:

____

____

Date: ____________ Consent Signature: ______________________________

Participant (if over the age of 18), Parent or Guardian

A COPY OF THE CLIENT'S COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM

(02/12)

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Student Health History

General Information:

Name: ____

DOB: ___________ Age: ______ Height: ______ Weight: ______ Gender: M F

Address: ______________________ City: ____________ State: _____ Zip: _____

Email: ____

Phone: ________________________ Alternative: ________________________

School/Employer______________________________________

Parent/Legal Guardian's Name: __________________________

Address (if different): ________________________________

Phone: ____________________________

Caregiver (if applicable): ______________________________

Phone: ___________________________

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, 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?)

____
____
____
____

Signature: ____________________________________ Date: ____________________
Participant (if over 18), Parent or Legal Guardian

PROTECTIVE EQUESTRIAN HEADGEAR AGREEMENT AND RELEASE

[TO BE COMPLETED WHEN RIDER WEARS HELMET OFFERED BY THIS PROVIDER]

Graz'n Acres Therapeutic Riding Center
Provider's name - hereinafter known as **"This Provider"**

Location: *Graz'n Acres Farm 14492 Ivor Road Sedley, VA 23878*

PLEASE READ CAREFULLY BEFORE SIGNING

PRINT NAME OF STUDENT: ______________________

ADDRESS OF STUDENT: ______________________

This **Provider** has offered and provided, at my request, an equestrian helmet that meets or exceeds SEI certification - **ASTM F 1163** standards for use when riding or near horses.

I, for myself and on behalf of my child and/or legal ward, heirs, administrators, personal representatives or assigns, release and discharge This Provider and their respective officers, directors, employees, agents, representatives, insurers, assigns, and others acting on their behalf, of and from all claims, demands, or causes of action, whether the same be known or unknown, anticipated or unanticipated, resulting from or arising out of bodily injury or property damage that may be sustained, or property damage which may occur, as a result of the use of the helmet provided.

I also understand that neither **This Provider**, nor its employees can guarantee the suitability of any helmet provided.

SIGNER STATEMENT OF AWARENESS

I/WE, THE UNDERSIGNED, HAVE READ THE FOREGOING STATEMENT CAREFULLY BEFORE SIGNING AND DO UNDERSTAND ITS WARNINGS, ASSUMPTION OF RISK, AND RELEASE OF LIABILITY.

______________________ DATE __________
SIGNATURE OF STUDENT (ADULTS ONLY)

______________________ FOR ______________________ DATE __________
SIGNATURE OF PARENT or LEGAL GUARDIAN — NAME OF STUDENT (PLEASE PRINT)

______________________ FOR ______________________ DATE __________
SIGNATURE OF PARENT or LEGAL GUARDIAN — NAME OF STUDENT (PLEASE PRINT)

OWNERS NAME AND ADDRESS *Cyndi M.A. Raiford, Executive Director* OWNERS PHONE *(757) 653-9615*

Graz'n Acres Therapeutic Riding Center OWNERS PHONE __________

14492 Ivor Road Sedley, VA 23878

Graz'n Acres Therapeutic Riding Center
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SESSION POLICY AND PROCEDURES

(Effective 1 January 2013)

Graz'n Acres TRC goal is to maintain a high quality therapeutic riding and driving program. The policies and procedures below have been created to help us serve everyone better and to also ensure all aspects of our organization run smoothly and efficiently. We welcome any and all input from participants, their parents and legal guardians concerning changes to our policies and procedures.

1. Participants should arrive before the starting time of a lesson to ensure adequate time for fitting a riding helmet, using the restroom, etc. Any participant more than 10 minutes late for a lesson will not be permitted to ride or drive that day. A short barn lesson will be provided instead.

2. Participants should wear long pants. A shoe/boot with a heel is preferable to tennis shoes. Helmets are provided by the center meeting ATSM-SEI certification.

3. Barn lessons on horsemanship skills are an important part of the overall horse education. Barn lessons will be held during inclement weather in lieu of riding/driving. For extremely severe weather, such as tornadoes, hurricanes, snow storms, etc., a make-up lesson will be held at a later date. Barn lessons may also be held due to horse injuries/sickness, excessive heat or lack of volunteers for the night.

4. **Tuition fees for the entire session are due and payable before the start of the session.** A typical session will be eight (8) weeks and tuition is $200.00. **An administrative fee of $40.00 is charged for any student canceling a session once scheduled.** This is to avoid last minute cancellations or no shows that prevent us from including another student from our growing waiting list.

5. All lessons are private at this time. All private lessons will last approximately 25-30 minutes.

6. Makeup lessons may be provided for illness or emergencies if advance notice is provided and if it is possible to reschedule. If the center cancels a lesson, make-up lessons will be provided. It is very difficult to schedule make-up lessons because of the number of participants we serve and our volunteers have other time commitments. If a participant is absent for a scheduled lesson for reasons other than illness or emergencies and/or advance notice (24 hours) is not provided, make-ups will not be given. Those participants missing more than three lessons of the session with non-medical reasons will be canceled for the rest of the session. We ask that you please notify us of last minute emergencies as soon as possible.

7. Pets are not allowed on the center premises at any time due to safety concerns.

8. Due to the nature of therapeutic riding and driving and the need to ensure the health and soundness of our older horses, instructor and volunteers, weight of a rider is considered a safety issue. We encourage families to talk with the instructor if there is a concern and welcome input. Driving is an option for those we cannot safely mount and ride.

9. Those participants on the waiting list will be included as soon as possible. Every attempt will be made to allow the influx of new participants to the center for each session.