

Bitterroot Therapeutic Riding

Member North American Riding for the Handicapped Association
Celebrating our 10th Year of Service in the Bitterroot & Missoula Valley
Special Olympics of Montana 'Organization of the Year'

2010

Dear Prospective Participant,

We invite you to be part of our program. BTR is conducting classes year round and we ask that you present a release from your medical professional or parent prior to evaluation. Our sessions are scheduled monthly for one hour a week and taught by an instructor certified by the North American Riding for the Handicapped Association. Prior to payment we will evaluate your application to make sure that we can be of help and that your medical and/or parental consent has been provided. We will then schedule an on-site evaluation to best address your needs and goals. Our schedule is designed around yours. Just let us know what day best suits your busy life and we will try to accommodate. The following non –refundable fee options are available:

Standard Rate: Private Lessons - \$55.00 per week – Group Lessons - \$45.00 per week

Please make your payment to BTR after your one time therapeutic riding evaluation at a cost of \$50.00. Student scholarships are available upon request and review of your specific needs. We ask that you fill out the enclosed forms and include any medical or personal information you feel will help us make your riding more enjoyable and beneficial.

Thank you, we look forward to having you in our “BTR” family.

Linda Olson
Program Director

Bitterroot Therapeutic Riding is a 501(c)3 Charitable Non-Profit Organization
BTR, 599 Popham Lane, Corvallis, MT 59828
Phone/Fax (406) 961-2999 • Cell (406) 880-6599
bitterrootriding.org • btr@bitterrootriding.org

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Participant's Application and Health History

GENERAL INFORMATION

Participant _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M ___ F ___

Address: _____ S.S.#: _____

Phone: _____ Alternate Phone #: _____

Email: _____

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 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			

Date: _____

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Dear Health Care Provider:

Your patient, _____
(participant's name)
is interested in participating in supervised equine activities.

In order to safely provide the 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 neurological 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.

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Participant's Medical History & Physician's Statement

Participant _____
 DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M _____ F _____
 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 Downs 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: _____

Authorization for Emergency Medical Treatment Form

Name: _____ DOB: _____

Address: _____ S.S.#: _____

Phone: _____ Alternate Phone #: _____

Physician's Name: _____ 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:

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/are unable to be reached.

Date: _____ Consent Signature: _____

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

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

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Release executed on this _____ of _____ 2 _____ by (Name) _____.

Address: _____

Phone: _____ Date of Birth _____

Herein referred to as Releasor to Bitterroot Therapeutic Riding, Don and Linda Olson, and Olson Farms of Corvallis, Montana, herein referred to as Releasee.

Releasor, being of lawful age, in consideration of being permitted to participate in horseback riding, or other related activities, does for himself, his spouse, his legal representatives, heirs, executors, administrators, and assigns, hereby release, waive and discharge Releasee, its officers, members, owners agents, representatives, lessees, insurers, their administrators, representatives, and executives of and from any and every claim, demand, action or right of whatever kind of nature, either in law or in equity arising from or by reason of any bodily injury or personal injury know or participation in horseback riding, or any other related activity in connection with horseback riding, or training, whether negligence of the Releasee's, their employees, agents, representatives, heirs, administrators or executors.

The Releasor, being of lawful age, acknowledges and assumes all such risks associated with the use, handling, and riding or a horse, or other related activities and hereby waives and releases and forever discharges, whether by Releasor's negligence or not, for himself, his spouse, his legal representatives, heirs, executors, administrators, and assigns, and hereby releases, waives and discharges Releasee, its officers, members, owners, lessees, insurers, their administrators, representatives and executives of and from any and every claim, demand, action or right of whatever kind of nature, either in law or in equity arising out of or by reason of any bodily injury for personal injury known or unknown, death or property damage, resulting or to result from any accident, incident, or occurrence, which may occur as a result of participation in horseback riding, training, or any other related activity, or activities at the premises or Releasees, their employees, representatives, heirs, administrators or executors.

The Releasor, being of lawful age, agrees to hold the Releasee, its officers, members, owners agents, representatives, lessees, insurers, their administrators, representatives and executives harmless of and from any and every claim, demand, action or right of whatever kind or nature, either in law or in equity arising from or by reason of any bodily injury or personal injury known or unknown, death or property damages, resulting or to result from any accident, incident or occurrence, which may occur as a result of participation in horseback riding, training, or any other activities whether negligence of the Releasee's, their employees, agents, representatives, heirs, administrators or executors, in connection with the use of the horses or equipment.

The Releasor, being of lawful age, acknowledges and agrees that the Releasee or its agents or employees have made no representation of nor assume responsibility for a particular horse being fit for a particular rider.

The Releasor, being of lawful age, further releases the Releasee, its officers, members, owners agents, representatives, lessees, insurers, or assigns from any claim whatsoever on account of first aid, treatment or service rendered the Releasor, being of lawful age, during his participation in the activities hereinbefore described.

The use of any gender herein shall be deemed to be or include the other genders, the use of the singular herein shall be deemed to be or include the plural and vice versa, and the use of any pronoun shall be deemed to be or include any other pronouns, wherever appropriate.

This release contains the entire agreement between the parties hereto and the terms of this release are contractual and not a mere recital.

Releasor, being of lawful age, further states that he has carefully read the foregoing release and knows the contents thereof and signs this release as his free act.

Releasor, being of lawful age, further acknowledges by signing the Release that there are not blanks remaining in the Release.

IN WITNESS THEREOF, Releasor, being of lawful age, has executed the Release, the day and year first above written.

Releasor: _____ Witness: _____
(If not of legal age, must be signed by parent or guardian.)

I have read the above release and understand all terms. I understand that this Release is a legal and binding document and affects my rights.

Releasor: _____ Witness: _____
(If not of legal age, must be signed by parent or guardian.)

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Scholarship Application

Date _____

I _____ DO HEREBY APPLY FOR SCHOLARSHIP FUNDING. I UNDERSTAND THAT THE \$40.00 EVALUATION FEE IS NOT INCLUDED IN SCHOLARSHIP FUNDING ALLOWANCES.

I CAN PAY \$ _____ FOR A FOUR (4) WEEK SESSION. I AM APPLYING FOR ADDITIONAL SCHOLARSHIP FUNDING IN THE AMOUNT OF \$ _____. I WILL THANKFULLY PROVIDE MY SPONSOR AND BITTERROOT THERAPEUTIC RIDING WITH A THANK YOU LETTER AND PHOTOGRAPH NO LATER THAN THE COMPELTION OF THE FOUR WEEKS.

NUMBER OF PEOPLE LIVING IN HOUSEHOLD _____.

MONTHLY HOUSEHOLD INCOME (BEFORE TAXES AND DEDUCTIONS).
\$ _____

IS A STUDENT/CLIENT RECEIVING ANY PUBLIC BENEFITS? YES NO
IF YES, WHAT IS THE SOURCE?

EXTENUATING CIRCUMSTANCES:

DO YOU SUBSCRIBE TO ANY OF THE FOLLOWING?

SECTION 8 HOUSING _____	SCHOOL LUNCH _____
MEDICAID _____	WELFARE _____
RENTAL ASSISTANCE _____	LIEAP _____
FOOD STAMPS _____	

SIGNATURE OF STUDENT/CLIENT, PARENT AND/OR GUARDIAN

SIGN _____

PRINT _____ DATE _____