



at the Kentucky Horse Park  
A Therapeutic Experience  
P.O. Box 13155 Lexington, Kentucky 40511 (859) 231-7066

March 4, 2009

Dear Participants and Parents:

Team CKRH is extremely excited that the long awaited MOVING DAY has finally arrived! When CKRH re-opens in 2009, we will be in our new facility on Walt Robertson Drive, located in the KY Horse Park. Please visit our website for a detailed map and directions. The indoor arena will allow us to provide activities through a variety of weather conditions and after dark. The tobacco barn on the hill has felt like home for many participants, families, volunteers and staff over the years. To ensure the new state of the art facility feels equally like home, we have scheduled a series of volunteer orientations, trainings and participant family meetings. We want everyone to have an opportunity to become “at home” in the new facility prior to lessons. Please review the schedule and reserve a date that works well for you. It is strongly encouraged that all participants and caregivers attend a **participant and family orientation**. Please RSVP to Denise Spittler at [denise@ckrh.org](mailto:denise@ckrh.org).

**Participant and Family Orientation** will include snacks, fellowship, tour of the facility, distribution of 2009 participant handbook and a walk through of the lesson day/evening experience.

*Who should attend?* All participants and caregivers

*Dates offered Weeknights:* May 18<sup>th</sup>, 19<sup>th</sup>, 20<sup>th</sup>, 21<sup>st</sup>, 22<sup>nd</sup> *Time:* 6:30pm to 8:00pm

*Dates offered Weekends:* May 16<sup>th</sup> *Time:* 9:30am to 11:00am

**Participant Assessments** will include an evaluation to determine the appropriate activity, session/lesson and horse for the participant.

*Who should attend?* All new participants, previous participants not participating in 2008 or previous participants with a medical change since last participation

*Dates offered:* Various dates in April as scheduled between family and program director. To participate in June an assessment must be scheduled prior to May 1<sup>st</sup>, if required.

### Important Lesson Dates

**March 4<sup>st</sup>** – Therapeutic riding registration begins. Download forms from [www.ckrh.org](http://www.ckrh.org).

**April 24<sup>th</sup>** - Participant registration **DEADLINE** for Session 1 Therapeutic Riding

**May 29<sup>th</sup> through July 2<sup>nd</sup>** – SESSION 1 Therapeutic Riding classes in the day and evening

**July 8<sup>th</sup>** - Participant registration **DEADLINE** for Session 2 Therapeutic Riding

**August 17<sup>th</sup> through October 24<sup>th</sup>** – SESSION 2 Therapeutic Riding classes in the day and evening

**SESSION 1 LESSON COST:** \$130.00 for five weekly one hour group lessons OR \$104.00 for four weekly one hour group lessons. Actual time riding the horse will be about 40 minutes.

OVER



Steps to Registration:

1. Download all forms from [www.ckrh.org](http://www.ckrh.org). Complete **ALL** forms. (Registration will not be accepted with missing information.)
2. Have physician sign physician statement.
3. Complete lesson request page indicating availability.
4. Mail completed packet to: CKRH, P.O. Box 13155, Lexington KY 40511  
ATTN: Denise Spittler
5. Participants will be notified in writing of their scheduled day and time. First-time participants will be contacted to schedule a participant assessment.

Completed registration packets will be dated and numbered upon receipt at CKRH. Participants will be matched with other riders with similar skills and abilities to form appropriate group lessons. Lessons will be filled on a first-come-first-served basis. When all rider opportunities have been filled, participants with completed forms will be placed on a waiting list and may have the opportunity to participate during future sessions.

First-time participants, previous participants not participating in 2008 or previous participants with a medical change since last participation must visit CKRH for an assessment prior to being scheduled for a lesson.

**If you are unable to print these documents please contact the office at 859-231-7066 and we will be happy to mail a set of the documents. Should you have any questions about the lessons offered or do not find an option you desire, please give me a call so that we may insure your needs are met.**

*Denise Spittler*

Denise Spittler  
Program Director



## LESSON REQUEST

**Session II Dates:** August 17th – October 24th  
**REGISTRATION DEADLINE:** July 8th

Please enroll \_\_\_\_\_ Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_

Please indicate the **days** and **times** you are available to participate. This will directly affect appropriate class placement. Please indicate days and times in order of preference. These will be given every consideration. Most classes will be about one hour in length.  
**Please be as specific as possible on times available.**

Time of Day	Mon	Tues	Wed	Thurs	Fri	Sat
9:30 am – 1:00 pm						
1:00 pm – 4:00 pm						
4:00 pm – 6:00 pm						No lessons offered
6:00 pm						No lessons offered
7:00 pm						No lessons offered

**SERVICES:** Please describe the type of services you would be interested in receiving. For example: Pony Club or a class focused on sensory integration, or therapeutic driving. Please refer to the “Program” page of the CKRH website for a complete description of services.

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**INSTRUCTOR REQUEST:** Do you have an instructor preference? Y N  
 If yes, please write in instructor name. \_\_\_\_\_

\_\_\_\_\_ I am not interested in riding during session I. However, please send me riding registration information for session II.

\_\_\_\_\_ I am not interested in riding. Please remove me from the mailing/waiting list. I will contact CKRH when interested.



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Riding Participant's Registration and Release Form
Therapeutic Riding and Driving Program

Participant's Name: Age: DOB
Address: City/State/Zip:
Home phone: Cell phone: Email:
Employer or School: Phone:

Parent/Legal Guardian:
Address: City/State/Zip:
Home phone: Cell phone: Email:
Employer: Phone:

I hereby consent for the above information to be maintained in the CKRH database so that I may receive information about the program. Signature: Date:
Parent/guardian if rider under 18

How did you hear about the program?
New Participant Returning Participant Date of Last Participation:

Liability Release

(Participant's Name) would like to participate in the Central Kentucky Riding for Hope, Inc. program. I acknowledge the risks and potential for risks of horseback riding, hippotherapy and horse related activities. However, I feel that the possible benefits to myself/my son/my 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 forever all claims for damages against Central Kentucky Riding for Hope, Inc. and The Kentucky Horse Park, its Board of Directors, Employees, Instructors, Therapists, Aides, Volunteers, Equines, Equine Owners, Equipment and Operating Site for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating at Central Kentucky Riding for Hope, Inc.

"WARNING: Under Kentucky law, a farm animal activity sponsor, farm animal professional or other person does not have the duty to eliminate all risks of injury of participation in farm animal activities. There are inherent risks of injury that you voluntarily accept if you participate in farm animal activities."

Signature: Date:
Signature of parent/guardian if rider under 18

Photo Release (Please sign 1st or 2nd option, do not sign both)

I hereby consent to and authorize the use and reproduction by Central Kentucky Riding for Hope, Inc. of any and all photographs and any other audiovisual material taken of me/my son/my daughter/my ward for promotional material, educational activities, exhibits, electronic publications (including the World Wide Web) or for any other use for the benefit of the program.

Photo Release Signature: Date:
Parent/guardian if rider under 18

Do Not Photograph Signature: Date:
Parent/guardian if rider under 18

PLEASE COMPLETE OTHER SIDE





### Authorization for Emergency Medical Treatment

Participant       Staff       Volunteer

Name: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

Policy # \_\_\_\_\_

Allergies to medication: \_\_\_\_\_

Current Medication: \_\_\_\_\_

### Person(s) to be contacted in case of an emergency:

1. Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone \_\_\_\_\_

2. Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone \_\_\_\_\_

3. 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 Central Kentucky Riding for Hope, Inc. to:

1. Secure and retain medical treatment and transportation, if needed.
2. Release participants / 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 listed above is unable to be reached.

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

Signature of parent/guardian if rider is under 18

### 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.

- Parent or legal guardian will remain on site at all times during equine assisted activities
- In the event emergency treatment/aid is required, I wish the following procedures to take place:

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

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

Signature of parent/guardian if rider is under 18



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### Participant's Medical History and Physician's Statement

This form is to be completed annually.

**Participant's Name:** \_\_\_\_\_ **Age:** \_\_\_\_ **DOB:** \_\_\_\_\_ **Male/Female**  
**Diagnosis:** \_\_\_\_\_ **Date of Onset:** \_\_\_\_\_  
**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Date of last Tetanus Shot:** \_\_\_\_\_  
**Seizures: Type:** \_\_\_\_\_ **Controlled: Yes/No** **Date of last seizure:** \_\_\_\_\_  
**Shunt present? Y N** **Date of last revision:** \_\_\_\_\_  
**Medications:** \_\_\_\_\_

**For persons with Down Syndrome:**

Cervical X-Ray for Atlantoaxial Instability: Positive \_\_\_\_ Negative \_\_\_\_ X-Ray Date \_\_\_\_\_  
Subsequent annual clinical exam (by physician who is knowledgeable in AAI condition) reveals symptoms of Atlantoaxial Instability?: Yes \_\_\_\_ No \_\_\_\_ Date of Exam \_\_\_\_\_

Please indicate current or past special needs, concerns and/or surgeries in any of the following areas by circling yes or no. If yes, please comment.

Auditory: Y N \_\_\_\_\_  
Visual: Y N \_\_\_\_\_  
Tactile Sensation: Y N \_\_\_\_\_  
Speech: Y N \_\_\_\_\_  
Cardiac: Y N \_\_\_\_\_  
Circulatory: Y N \_\_\_\_\_  
Integumentary/Skin: Y N \_\_\_\_\_  
Digestion: Y N \_\_\_\_\_  
Elimination Y N \_\_\_\_\_  
Immunity: Y N \_\_\_\_\_  
Pulmonary: Y N \_\_\_\_\_  
Neurological: Y N \_\_\_\_\_  
Muscular: Y N \_\_\_\_\_  
Balance: Y N \_\_\_\_\_  
Orthopedic: Y N \_\_\_\_\_  
Allergies: Y N \_\_\_\_\_  
Learning Disability: Y N \_\_\_\_\_  
Cognitive: Y N \_\_\_\_\_  
Emotional/Psychological Impairment: Y N \_\_\_\_\_  
Behavioral Y N \_\_\_\_\_  
Pain: Y N \_\_\_\_\_  
Other: Y N \_\_\_\_\_

**Mobility:** Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N

Braces / Assistive Devices: \_\_\_\_\_

**Special Precautions:** \_\_\_\_\_

**OVER TO COMPLETE**



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

Dear Health Care Provider:

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

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.

If you have any questions or concerns regarding this patient's participation in therapeutic horseback riding, hippotherapy and horse related activities, please do not hesitate to contact the operating center at the address/phone indicated on reverse.

Orthopedic

Spinal Fusion: Y N \_\_\_\_\_
Spinal Instabilities/Abnormalities: Y N \_\_\_\_\_
Atlantoaxial Instabilities: Y N \_\_\_\_\_
Scoliosis: Y N \_\_\_\_\_
Kyphosis: Y N \_\_\_\_\_
Lordosis: Y N \_\_\_\_\_
Hip/Joint Subluxation and Dislocation: Y N \_\_\_\_\_

Osteoporosis: Y N \_\_\_\_\_
Pathologic Fractures: Y N \_\_\_\_\_
Coxas Arthrosis: Y N \_\_\_\_\_
Heterotopic Ossification: Y N \_\_\_\_\_
Osteogenesis Imperfecta: Y N \_\_\_\_\_
Cranial Deficits: Y N \_\_\_\_\_
Spinal Orthoses: Y N \_\_\_\_\_
Internal Spinal Stabilization Devices: Y N \_\_\_\_\_

Neurological

Hydrocephalus/shunt: Y N \_\_\_\_\_
Spina Bifida: Y N \_\_\_\_\_
Tethered Cord: Y N \_\_\_\_\_
Chiari II Malformation: Y N \_\_\_\_\_
Hydromyelia: Y N \_\_\_\_\_
Paralysis due to Spinal Cord Injury: Y N \_\_\_\_\_
Seizure Disorders: Y N \_\_\_\_\_

Medical/Surgical

Allergies: Y N \_\_\_\_\_
Recent Surgery: Y N \_\_\_\_\_
Poor Endurance: Y N \_\_\_\_\_
Cancer: Y N \_\_\_\_\_
Diabetes: Y N \_\_\_\_\_
Peripheral Vascular Disease: Y N \_\_\_\_\_
Varicose Veins: Y N \_\_\_\_\_

Hemophilia: Y N \_\_\_\_\_
Hypertension: Y N \_\_\_\_\_
Serious Heart Condition: \_\_\_\_\_
Stroke (Cerebrovascular Accident): Y N \_\_\_\_\_

Secondary Concerns:

Behavior problems: Y N \_\_\_\_\_
Weight control disorder: Y N \_\_\_\_\_
Thought control disorder: Y N \_\_\_\_\_
Acute exacerbation of chronic disorder: Y N \_\_\_\_\_
Indwelling catheter: Y N \_\_\_\_\_

Physician's Statement

Given the diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the NARHA center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the NARHA center for ongoing evaluation to determine eligibility for participation.

Physician's name /title (please print): \_\_\_\_\_ MD DO NP PA other \_\_\_\_\_

License/UPIN Number: \_\_\_\_\_

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

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_