



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

Participant / Client Registration and Release Form
All Mounted Programming

Participant's Name: Age: DOB

Male Female Kentucky County of Residence

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: (Must list two contacts.)

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

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. A parent or legal guardian **MUST** remain on site at all times during equine assisted activities.

Non-Consent Signature: _____ Date: _____

Signature of parent/guardian if rider is under 18

In the event emergency treatment/aid is required, I wish the following procedures to take place:



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Participant / Client Medical History and Physician's Statement

This form is to be completed annually.

Dear Health Care Provider:

Date: _____

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.

Diagnosis: _____ Date of Onset: _____

Seizures: Type: _____ Controlled: Yes/No Date of last seizure: _____

Current Height _____ Current Weight _____

Shunt present? Y N Date of last revision: _____ Date of last Tetanus Shot: _____

Medications: _____

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: _____

This form is to be completed annually.

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 _____

Patient weight during last exam _____ Date of exam _____ Height _____

Orthopedic

Spinal Fusion: Y N _____

Spinal Instabilities/Abnormalities: 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: _____

To the best of my knowledge the previous two pages of medical history are true and accurate:

Signature of Participant OR Parent/Guardian if under age of 18: _____

Rider Weight Policy

CKRH will adhere to the following guidelines when making decisions regarding rider weight. Each guideline is in place so that every member of the team (horse, rider and volunteer) may have a safe experience. Horse health, rider's weight distribution, rider's ability to dismount without hurting the horse and each volunteer's ability to safely assist a rider are all very important considerations.

- Each horse will be evaluated as an individual and assigned a maximum carrying weight. Considerations will be made for age and health/soundness.
- Each rider will be evaluated as an individual. Considerations will be made for rider's height, range of motion, balance and ability to dismount independently.
- Each team will be evaluated to ensure that an appropriate volunteer/instructor is available to complete all emergency procedures including an emergency dismount.
- In general the following rider height to weight ratios will be followed.

Rider Height	Maximum Weight
Under 5'0 tall	150 lbs
5' to 5'6 tall	175 lbs
5'7 to 6' tall	200 lbs
6'1 to 6'5 tall	250 lbs
Current CKRH riders not in compliance with the above height to weight ratios must meet previous guidelines of 200 lb weight maximum and an available horse that can carry that weight.	

- The maximum amount of weight each horse can carry is determined using the following formula:
 - 20% of the horse's weight minus the weight of tack minus 10 pounds for degrees of unbalanced rider movement. (Unbalanced rider movement is determined through instructor observation while rider is mounted and through a balance exam while non-mounted.) Other considerations are observation of equine movement while carrying weight and veterinary input.
- Each horse has a maximum number of lessons they may participate in per week. Therefore the number of horses available to carry higher weights may be limited.
- If, after an evaluation by at least two CKRH staff members, a rider is determined to be over the weight limit of any available CKRH horse, the participant has the option to participate in other CKRH programs such as therapeutic carriage driving and therapeutic horsemanship.
- Riders may be asked to weigh-in on CKRH scales at any point during their riding sessions.