Mailing: **SAVANNAH STATION THERAPEUTIC RIDING PROGRAM** **Physical:**
P.O. Box 852084 **9304 N. U.S. Hwy 81**
Yukon, OK 73085 **El Reno, OK 73036**

Dear Prospective Participant,

Thank you for your interest in the Savannah Station Therapeutic Riding Program.

Please complete and return via mail the enclosed application. **PLEASE NOTE: APPLICATIONS MUST BE FULLY COMPLETED IN INK TO BE ACCEPTED.** If you or your child does not have a phone or email, simply write NA across the page. You will receive a phone call or email upon receipt of the application. We schedule a visit/evaluation to S.S.T.R.P after we receive your application and believe that we may have suitable openings in our schedule. The evaluation is the opportunity to determine if our services are a good fit and whether we can safely accommodate the applicant.

Applicants must be:

1. At least 4 years of age or older.
2. May not have a history of having uncontrolled Grand Mal seizures.
3. For Down Syndrome riders: Must have a recent Atlantoaxial Instability Verification.
4. Parents/Guardians of riders who wish to support the SSTRP through the contribution of their time to our Volunteer Program will need to fill out a Volunteer Application.

In order for everyone to get the most out of their experiences at Savannah Station Therapeutic Riding Program, we strive to provide the safest possible conditions and adhere to precautions and contraindications for participants established by PATH Intl. Please review the following SSTRP Policies:

1. A Participant Application must be turned in annually.
2. The acceptance and continuation of a participant depends on the availability of instructors, volunteers, and suitable horses.
3. Rider weight limit is subject to SSTRP's Height/Weight policy and horse availability (**185 pound maximum**).
4. SSTRP reserves the right at any time to refuse any participant that we cannot safely accommodate.
5. We ask parents/guardians/participants to inform us of any changes in health status of the participant.
6. When near/on horses, participants must wear ASTM-approved riding helmets, which SSTRP supplies. The participant may choose to purchase their own helmet but it must be ASTM-approved and examined by the instructor prior to use.
7. Appropriate clothing (i.e. closed-toe shoes with heels if possible) is required. **NO** sandals, flip flops, or bare feet. Long pants are recommended. Please no dangling earrings or anything around the neck (i.e. lanyards, necklaces, etc.).
8. Parents and family members who wish to assist during classes must fill out a Volunteer Application and attend a Volunteer Training prior to assisting in the ring.

Thank you for your interest in our program.

Mail this application to:

Savannah Station Therapeutic Riding Program

Attn: Program Coordinator

P.O. Box 852036

Yukon, OK 73085

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THERAPEUTIC PARTICIPANT APPLICATION

Date of Application: _____

Rider Name: _____

Date of Birth: ____/_____/_____ Height: _____ Weight: _____lbs. Gender: M F

Ethnicity: _____

Diagnosis: _____

School: _____

Rider Address: _____City: _____ State: _____ Zip: _____

Rider Ph (H): _____ Ph (W): _____ Ph I: _____

Rider Email: _____

Please Circle: Father Mother Guardian

Name: _____

Rider Address: _____City: _____ State: _____ Zip: _____

Ph (H): _____ Ph (W): _____ Ph I: _____

Email: _____

Please Circle: Father Mother Guardian

Name: _____

Rider Address: _____City: _____ State: _____ Zip: _____

Ph (H): _____ Ph (W): _____ Ph I: _____

Email: _____

How did you learn about the program? _____

Has the participant been in an equine-assisted therapy program before? Yes No

If yes, what program? _____

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PARTICIPANT LIABILITY RELEASE, PHOTO RELEASE

Liability Release

_____(participant) would like to participate in the Savannah Station Therapeutic Riding Program. I acknowledge the risks and potential for risks of working with horses/horseback riding. However, I feel that the possible benefits to myself/my child/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 Savannah Station Therapeutic Riding Program and Redlands Community College, their Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my child/my ward may sustain while participating in the Savannah Station Therapeutic Riding Program.
Signature_____Date_____

Photo Release

Please circle one: I DO I DO NOT

Consent to and authorize the use and reproduction by Savannah Station Therapeutic Riding Program of any and all photographs and any other audio/visual materials taken of me/my child/my ward for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature_____Date_____

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PARTICIPANT'S CONSENT FOR RELEASE OF INFORMATION

I hereby authorize (name of person/facility)_____

to release information from the records of (participant): _____ DOB: _____

The information is to be released to ***Savannah Station Therapeutic Riding Program*** 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 (I.H.P)
	Classroom Individual Education Plan (I.E.P.)
	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: _____

Relationship to Participant: _____

Please send materials to: Savannah Station Therapeutic Riding Program

P.O. Box 852084

Yukon, OK 73085

- **Information provided will be maintained in a secure location and only to be viewed by the Program Coordinator/Instructors and emergency medical personnel (in event of emergency).**
- **Please have the medical section filled out by a physician. This form will only be used if there are additional questions that must be answered by a medical professional.**

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Name: _____ DOB: _____ Ph: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Co: _____ 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 of 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 Savannah Station Therapeutic Riding Program to:

1. Secure and retain emergency 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 unable to be reached.

Date: _____ Consent Signature: _____

Participant, Parent, or Legal 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 agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

Date: _____ Consent Signature: _____

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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 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.

Orthopedic	Neurologic	Medical/Psychological	Other
Atlantoaxial Instability- include neurologic symptoms	Hydrocephalus/Shunt	Allergies	Age- under 4 years
Coxarthrosis	Seizure	Animal Abuse	Indwelling catheters/medical equipment
Cranial Defects	Spina Bifida/Chiari II Malformations/ Tethered Cord/ Hydromyelia	Cardiac Condition	medications- (e.g. photosensitivity)
Heterotopic Ossification/Myositis Ossificans		Physical/Sexual/Emotional Abuse	Poor Endurance
Joint Subluxation/dislocation		Blood Pressure Control	Skin Breakdown
Osteoporosis		Dangerous to Self or Others	
Pathologic Fractures		Exacerbations of Medical Conditions (e.g. RA, MS)	
Spinal Joint Fusion/Fixation		Fire Setting	
Spinal Joint Instability/Abnormalities		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-assisted activities, please contact us at:

Savannah Station Therapeutic Riding Program P.O. Box 852084 Yukon, OK 73085

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PHYSICIAN ASSESSMENT & HEALTH HISTORY

To be completed by physician

Date: _____ Participant: _____

Date of Birth: ____/_____/_____ Height: _____ Weight: _____lbs. Gender: M F

Primary Diagnosis: _____ Date of Onset: _____

Secondary Diagnosis: _____ Date of Onset: _____

Shunt Present: Y N Date of last revision: _____

Implants: _____

Special Precautions/Needs: _____

Down Syndrome Participants

For those with Down Syndrome: Neurologic Symptoms of Atlantoaxial Instability: Present Absent

Date of X-Ray: _____ Results: _____

(PATH Standard A18)

Seizure Disorder Participants

The following information is required for clients with Seizure Disorders. Would you consider this person's seizures to be (by medication):

Completely controlled Very well controlled Fairly controlled Not controlled

Type of Seizure: _____

Typical aura: _____

Typical motor activity during seizure: _____

Duration of seizure: _____

Current frequency of seizures: _____

Date of last seizure: _____

Description of Participant's behavior during post-ictal state: _____

_____

Post-ictal state duration: _____

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PHYSICIAN ASSESSMENT & HEALTH HISTORY CONTINUED

Date: _____ Participant: _____

Date of last Tetanus Shot: _____

Past Surgeries: _____

Prospective Surgeries: _____

Medications: _____

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

Braces/Assistive Devices: _____

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

	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			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that Savannah Station Therapeutic Riding Program will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person Savannah Station Therapeutic Riding Program for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Ph: _____ License/UPIN Number: _____