SAVANNAH STATION
THERAPEUTIC RIDING PROGRAM

Dear Prospective Participant,

Thank you for your interest in Savannah Station Therapeutic Riding Program!

Please complete and return mail the enclosed application. If there is not a phone or an email, please write NA where necessary. Once the completed application is received and reviewed you will be notified. Based on openings in our class schedule, a visit and evaluation will be scheduled to determine if our services are a good fit for the applicant.

Savannah Station Therapeutic Riding Program adheres to the highest levels of best practices and safety and follows the standards and policies established by PATH Intl. Please review the following SSTRP Policies:

Applicant Requirements:

1. Age four years or older.
2. Savannah Station's rider weight limit is 185 pounds.
3. No history of uncontrolled Grand Mal seizures.
4. Must have a recent Atlantoaxial Instability Verification for applicants with Down Syndrome.
5. A healthcare provider must assess participant and sign and date physician forms (last three pages).
6. The acceptance and continuation of a participant depends on the availability of instructors, volunteers and suitable horses.
7. Parents/Guardians must inform us of any changes in health status for participant.
8. Participants must wear an ASTM-approved riding helmet supplied by SSTRP or have one of their own.
9. Appropriate clothing is required. Foot protection with close-toed boots with heels is preferred. No open toed shoes will be allowed. Long pants are recommended. No dangling jewelry is allowed in the arena.
10. Parents/Guardians of riders who want to be in the arena with their rider must complete a Volunteer Application and attend Volunteer Orientation.
11. A Participant Application must be turned in annually.
12. SSTRP reserves the right at any time to refuse any participant that cannot be safely accommodated.

At this time there is a waiting list for services. To be added to the waiting list, we must receive all but the healthcare providers portion of the completed application.

Each rider starts out with full support (three volunteers). If you have three people who are willing to volunteer to help you in class, that helps move you up the waiting list.

We look forward to visiting with you!

Mail completed application to:
Savannah Station Therapeutic Riding Program
P. O. Box 852084, Yukon, OK 73085
405-422-6239
info@savannahstation.org
savannahstation.org

Savannah Station TRP
P. O. Box 852084
Yukon, OK 73085
(405) 422-6239
info@savannahstation.org

Therapeutic Participant Application

Participant: _____DOB: _____

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

Diagnosis: _____ Date of Onset: _____

Address: _____

City: _____ Zip:_____

Phone: _____ Email: _____

Name Parent/Legal Guardian: _____

Relationship: _____

Address (if different than above):

_____

City: _____ Zip:_____

Phone: _____ Email: _____

School/Employer: _____

Phone: _____ Email: _____

Referral Source: _____

Phone: _____ Email: _____

Does participant have past experience in an equine-assisted therapy program? Yes No

If so, which program? _____

How did you hear about Savannah Station? _____

Do you have three people who will volunteer to help you in class? Yes No

Goals: *(What would participant like to accomplish in the program?)*

_____

_____

Health History

Please indicate current or past special needs in the following areas:

Area	Y	N	Comments
Vision			
Hearing			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

Medications: (*That we may need to be aware of*)

_____

_____

Physical Function: *(Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)*

_____

_____

Psycho-social Function: *(Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)*

_____

_____

Signature: _____ Date of Application: _____

Participant Liability Release

Participant, _____, is participating in the Savannah Station Therapeutic Riding Program. I acknowledge the risks and potential for risks of working with and of being around horses/horseback riding. However, I believe 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 that I/my child/my ward may sustain while participating with the Savannah Station Therapeutic Riding Program.

Signature: _____ Date: _____

(PATH Standard A14)

Confidentiality Agreement

I understand that all information, written and verbal, about participants at Savannah Station Therapeutic Riding Program is confidential and will not be shared with anyone without the express written consent of the participant and their parent/guardian in the case of a minor.

Signature: _____ Date: _____

(PATH Standard A22)

Photo Release

I DO / 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 minor child or my ward for promotional purposes, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

(PATH Standard A15)

Savannah Station TRP
P. O. Box 852084
Yukon, OK 73085
(405) 422-6239
info@savannahstation.org

Authorization for Emergency Medical Treatment

Name: _____ DOB: _____**Cell**: _____

Healthcare Provider's Name: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to Medications: _____

Current Medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Cell: _____

Name: _____ Relation: _____ Cell: _____

In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while on the property of the organization, I authorize Savannah Station Therapeutic Riding Program to:

1. Secure and retain emergency medical treatment and transportation as needed.
2. Release client records upon request to the authorized personnel or agency involved in rendering emergency medical 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.

Consent Signature: _____ Date: _____

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 on the property of the organization. In the event emergency treatment/aid is required, I wish the following procedures to be taken:

_____

Non-Consent Signature: _____ Date: _____

Savannah Station TRP
P. O. Box 852084
Yukon, OK 73085
(405) 422-6239
info@savannahstation.org

Participant's Consent for Release of Information

This form will only be used if additional information is necessary and must be provided by a medical professional.

I hereby authorize: _____
(person or facility)

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

To be released to **Savannah Station Therapeutic Riding Program** for the purpose of developing an equine-assisted activity program for the named participant. The information to be released is indicated below:

- Medical History
- Physical Therapy evaluation, assessment and program plan
- Occupational 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: _____

Relation to Participant: _____

Thank you!

SAVANNAH STATION
THERAPEUTIC RIDING PROGRAM

TO BE COMPLETED BY HEATHCARE PROVIDER

Dear Health Care Provider:

Your patient, _____, is interested in participating in supervised equine-assisted activities.

In order to safely provide this service, Savannah Station TRP 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-assisted activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability - include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/
Tethered Cord/Hydromyelia

Other
Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you for your assistance. If you have any questions regarding this patient's participation in equine-assisted activities, please feel free to contact me.

Andi Holland
Executive Director

Savannah Station TRP
P. O. Box 852084
Yukon, OK 73085
(405) 422-6239
Ed1@savannahstation.org

Participant's Medical History and Physician's Statement

TO BE COMPLETED BY HEATHCARE PROVIDER

Participant: _____DOB: _____

Gender: M F Height: _____ Weight: _____

Address: _____

City: _____ Zip:_____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Date(s) of Onset: _____

Past/Prospective Surgeries:

_____

Medications:

_____

Seizure Type:

_____

Duration: _____ Frequency: _____ Motor Activity: _____

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 Down Syndrome*:**

Neurologic Symptoms of Atlantoaxial Instability (AAI): Present Absent

Date of x-ray: _____ **Result:** _____

HCP Signature/Title:_____ **Date:**_____

TO BE COMPLETED BY HEATHCARE PROVIDER

Please indicate current or past special needs in the following systems/areas, including surgeries.

Area	*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 TRP will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Savannah Station TRP for ongoing evaluation to determine eligibility for participation.

Health Care Provider's Name/Title: _____

Signature:_____Date: _____

Address: _____

Phone:_____ License/UPIN #: _____