



SVTRC

Swan View Therapeutic Riding Center, Inc.
7905 Briar Road
Azle Texas 76020
817-444-8499
www.svtrc.org



Thank you for expressing interest in SVTRC.

There is some paperwork that must be completed for each participant applicant. Please have the appropriate people complete the enclosed forms for each participant:

- Participant Application
- Getting to Know You
- Release Form
- Authorization for Emergency Medical Treatment
- Participant's Health History and Physicians Statement

Thank you for your interest in SVTRC, if you have any questions please contact me.

Cathleen Thatcher
Founder, Director, Head Riding Instructor

Swan View Therapeutic Riding Center, Inc.

Participant Application

(PLEASE PRINT)

Participant Name: _____ Date: _____

Parents or Guardian: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Aid Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

These times do not necessarily reflect the actual class schedule. Please check all times that the Participant would be available to ride. Mark the three preferred times with a 1, 2 or 3.

Tuesday

- 4:30 p.m.
 5:45 p.m.
 7:00 p.m.

Thursday

- 4:30 p.m.
 5:45 p.m.
 7:00 p.m.

Saturday

- 10:00 a.m.
 11:15 a.m.
 12:30 p.m.

Initial Participant Profile:

Has Participant ridden with Swan View or another NARHA Center before: Yes No .

If YES, which Center: _____

If yes, how many sessions _____; beginning year _____.

Has Participant ridden with another therapeutic riding program: Yes No . If yes, how long _____.

I/My child is: ambulatory non-ambulatory verbal non-verbal

I/My child sits independently: Yes No .

Additional comments: _____

For more information, contact Cathleen Thatcher

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svtrc@svtrc.org

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Swan View Therapeutic Riding Center, Inc.

Getting To Know You

Please fill out this page for our Participant Notebook. The Participant notebook is for the volunteers and staff to get to know a little bit about the participants they will be working with.

Date: _____

My full name is _____

Please call me: _____ . My Birthday is: _____
(name I go by)

I began riding at Swan View on _____
(date)

My interests or hobbies are:

My goals for riding therapy are:

Please supply any details about the Participant you think might be helpful to the volunteers / staff who will be working with him/her/you:

Speech: _____ Comprehension: _____

Vision: _____ Hearing: _____

Ambulatory Status: _____

Particular methods this Participant responds to: _____

We would like a photograph to be supplied with the application. If you do not have one, we will gladly take one for you.

Release Form

Liability Release:

_____ (Participant's Name), would like to participate in the Swan View Therapeutic Riding Center program. I acknowledge the risks and potential risks of horseback riding. However, I believe 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 Swan View Farm, Swan View Therapeutic Riding Center, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward, my family members or friends may sustain while participating in Swan View Therapeutic Riding Center's activities.

WARNING – Under Texas law (Chapter 87, Civil Practice and Remedies Code), an equine professional is not liable for an injury to or death of a participant in equine activities resulting from the inherent risks of equine activities.

Client, Parent or Guardian

Date

Photo (Media) Release

I DO

DO NOT

Consent to and authorize the use and reproduction by Swan View Therapeutic Riding Center of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or any other use for the benefit of the center.

Participant, Parent or Guardian

Date

Swan View Therapeutic Riding Center, Inc.

Authorization for Emergency Medical Treatment

Participant Staff Volunteer

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergic to medications: _____

Current Medications: _____

In the event of an emergency, contact:

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 at the center, I authorize Swan View Therapeutic Riding Center to:

1. Secure and retain medical treatment and transportation if needed.
2. Release participant records upon request to the authorized individual or agency involved in 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.

Date: _____ Consent Signature: _____

Participant, Parent or Legal Guardian, Signed in presence of 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 center. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date: _____ Non-Consent Signature: _____

Participant, Parent or Legal Guardian, Signed in presence of center staff

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

Swan View Therapeutic Riding Center, Inc.

Participant's Health History and Physician's Statement

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GENERAL INFORMATION

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Male Female

Address: _____ City, State, Zip code: _____

Phone: _____ Alternate Phone: _____

E-Mail Address: _____

Employer/School: _____

Employer/School Address: _____

Employer/School Phone: _____

Parent/Legal Guardian: _____

Parent/Legal Guardian Address (if different from above): _____ City, State, Zip code: _____

Parent/Legal Guardian Phone: _____

Signature of Participant (or Parent/Guardian if under 18): _____

HEALTH INFORMATION:

Diagnosis: _____

Current Medications: _____

For: _____

Seizure Type: _____ Controlled: _____ Date of Last Seizure: _____

Please indicate current or past problems and/or surgeries in the following areas:

Area	Yes	No	Comments
Vision			
Vision without correction:			Vision corrected to:
Hearing / Auditory			
Sensation			
Communications / Speech			
Heart / Cardiac			
Circulatory			
Breathing / Pulmonary			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			

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Participant's Health History and Physician's Statement

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Area	Yes	No	Comments
Pain			
Orthopedic/Bone/Joint			
Muscular			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Allergies			
Other			

Mobility:	Independent Ambulation: <input type="checkbox"/> Yes <input type="checkbox"/> No Crutches: <input type="checkbox"/> Yes <input type="checkbox"/> No Braces: <input type="checkbox"/> Yes <input type="checkbox"/> No Wheelchair: <input type="checkbox"/> Yes <input type="checkbox"/> No Please indicate any special precautions: _____
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<p>For Persons with Down Syndrome: Because of the nature of the activity of horseback riding, no individual diagnosed with Down Syndrome can be accepted for riding instruction without proof of negative diagnostic x-ray for Atlantoaxial dislocation condition taken after the age of 3 years.</p> <p>Cervical x-ray for Atlantoaxial Instability <input type="checkbox"/> Positive <input type="checkbox"/> Negative X-ray date _____</p> <p>Cervical Exam (done annually): <input type="checkbox"/> Positive <input type="checkbox"/> Negative Exam date _____</p>
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<p>To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications (found on following page).</p> <p>Physician Name (please print): _____</p> <p>Physician Signature: _____</p> <p>Address: _____ City: _____ State: _____ Zip: _____</p> <p>Phone (____) _____ Date _____</p>
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Please see the following page for precautions and contraindications

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Participant's Health History and Physician's Statement
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Information for Physician

The following conditions may suggest precautions and contraindications to therapeutic horseback riding. 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 Fusion/Fixation
Spinal Instability/Abnormalities
Spinal Fusion
Spinal Orthoses
Scoliosis
Kyphosis
Lordosis
Internal Spinal Stabilization Devices

Neurologic

Hydrocephalus/Shunt
Seizure Disorders
Spina Bifida
Chairi II Malformation
Tethered Cord
Hydromyelia
Paralysis due to Spinal Cord Injury

Other

Age – under 2 years
Age two to four years
Indwelling Catheters
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Blood Pressure Control
Cancer
Heart Conditions
Hemophilia
Medical Instability
Migraines
Peripheral Vascular Disease
Stroke (Cerebrovasuclar Accident)
Varicose Veins
Respiratory Compromise
Recent Surgeries
Exacerbations of medical conditions
Animal Abuse
Physical/Sexual/Emotional Abuse
Dangerous to self or others
Fire Settings
Substance Abuse
Thought Control Disorders
Weight Control Disorders

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