

CAPITAL AREA THERAPEUTIC RIDING ASSOCIATION

Post Office Box 339, Grantville, PA 17028-0339

(717) 469-7517

www.catra.net

Dear Friend:

Thank you for your interest in CATRA. To become a "CATRA" rider, it is necessary to have the enclosed forms completed and returned to us as soon as possible. There may be a waiting period to get a scheduled riding time depending on openings. We will be in touch with you. The enclosed forms are as follows:

Rider Registration Information, Parent/Student Release - these can be completed by you. Please sign where indicated and feel free to go into as much detail as needed.

Student Medical History, Physician's Authorization - to be completed by the physician most familiar with the rider. Sign these as necessary.

Physical Therapy Assessment - in the event that the rider is being treated by a Physical Therapist and/or Occupational Therapist - we need their input to design a quality riding program.

The demands on a therapeutic riding program instructor and director are many. Above all, we need to know as much about our riders as possible. Upon receipt of these forms, we may have to consult with your doctors and/or therapists to work with them and design a riding program best suited to the rider. All information received is treated as highly confidential.

A registration fee of \$35.00 is payable twice per calendar year. The fee is to be submitted with the rider's application to participate in a session of lessons, and it is indicated on that form. The registration fee will be used to supplement current administrative costs and program insurance.

Riding Lesson Fee is \$30.00 per lesson. Riders are asked to pay \$30.00 per lesson if they are able to pay that amount. In the event that partial or full sponsorship for lessons is needed, we ask the rider to help us find a sponsor for them. It has always been our policy "that no rider will be turned down for financial reasons".

If you have not visited the program, please call for an appointment. **Please do not wait for us to call you.** We look forward to meeting and working with you.

Most sincerely,

Ben Nolt

Ben H. Nolt, Jr.
Executive Director



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RIDER REGISTRATION INFORMATION

Rider's Name _____ Date of Birth _____

Address _____ Zip _____

Parent/Legal Guardian _____ Phone _____

Parent/Guardian occupation & employer: _____

Emergency Contact (name and number) _____

School District _____ School Attending _____

Rider's Physician/Medical Center _____ Phone _____

Physician's Address _____

Participant's physical, emotional or mental Disability _____

_____ Date of Onset _____

If physical disability, limbs affected _____

Allergies Yes _____ No _____ If yes, please list _____

Heart disease Yes _____ No _____ Respiratory disease Yes _____ No _____

High blood pressure Yes _____ No _____ Fainting Yes _____ No _____

Heat exhaustion Yes _____ No _____ Shunt Yes _____ No _____

Seizures Yes _____ No _____ If yes, are seizures controlled? Yes _____ No _____

Skin problems (current and past) Yes _____ No _____

Height _____ Weight _____

Bladder problems Yes _____ No _____

If yes, describe _____

Visual problems Yes _____ No _____

If yes, describe _____

Hearing problems Yes _____ No _____

If yes, describe _____

Subluxing or dislocating hips Yes _____ No _____

Current medication and dosage _____

Physical aids (check if applicable) Wheelchair _____ Walker _____ Canes _____ Glasses _____

Braces _____ Crutches _____ Hearing Aid _____ Contact lens _____

Other (i.e. splints) _____ Specify _____



Rider Registration Information (Cont'd)



Ambulatory status (please check)

Uses wheelchair _____ Walks with assistive devices _____
Non-Ambulatory _____ Walks independently _____

Please include any special problems (i.e. violent outbursts, emotional withdrawal, fears, any limitations, etc.) _____

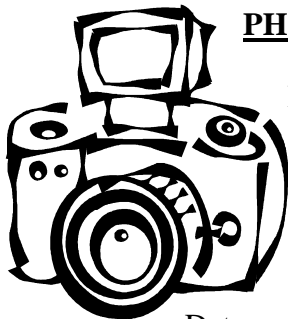
Additional information _____

LIABILITY RELEASE

_____ (rider's name) would like to participate in the Capital Area Therapeutic Riding Association program. I have discussed the risks and problems of horseback riding with my own/son's/daughter's/ward's doctor and acknowledge the risks and potential for risks in this activity. 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 Capital Area Therapeutic Riding Association, it's 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 and immediate family may sustain while participating in the Capital Area Therapeutic Riding Association.

Date: _____ Signature: _____
Relationship: _____
(self/mother/father/ Legal guardian)

PHOTO RELEASE: OPTIONAL



I hereby consent to and authorize the use and reproduction by Capital Area Therapeutic Riding Association of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.

Date: _____ Signature: _____
(client, parent, or guardian)

Riding session (circle) Fall Winter Spring Summer All Year

Best times (give several) _____

Lessons are \$30.00 each. A seasonal registration fee of \$35.00 must be enclosed for us to process this form. **PLEASE MAKE ALL CHECKS PAYABLE TO CATRA.**



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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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 CATRA to:

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

Client's Name: _____ Phone: _____

Address: _____ Zip: _____

In the event I cannot be reached, contact: _____ Phone: _____

contact: _____ Phone: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Co. : _____ Policy #: _____



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 below is unable to be reached.

Date: _____ Consent Signature: _____

Volunteer, parent, or guardian

Print Name: _____ Phone: _____

Address: _____ Zip: _____



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

Date: _____ Non-Consent Signature: _____

Volunteer, parent, or guardian

Print Name: _____ Phone: _____

Address: _____

ATTACH A COPY OF THE COMPLETED MEDICAL HISTORY.





PARENT OR STUDENT RELEASE

Name: _____ Date: _____

Address: _____ Zip: _____

Phone, Home: _____ Work: _____

Date of Birth: _____ Age: _____

Disability: _____ Date of Onset: _____

Height: _____ Weight: _____

Mother: _____ Father: _____

Guardian(s): _____

No student can be accepted for riding instruction until this form has been completed by the parent/parents and/or guardians. If the student is of legal age (21), he or she may complete the form without parent/parents or guardian(s) signature. Riding instruction will be under strict supervision and, although every effort will be made to avoid any accident, **NO LIABILITY** can be accepted by the Capital Area Therapeutic Riding Association.

Physician's Name: _____

Address: _____ Zip: _____

Office Phone: _____

Physical Therapist and/or Occupational Therapist: _____

Address: _____ Zip: _____

Phone, Home: _____ Work: _____

I would like _____ to have riding instruction and I have discussed this with the student's doctor. I understand that **NO LIABILITY** can be accepted by the Capital Area Therapeutic Riding Association, its officers, trustees, agents, employees, representatives, successors, or assigns.

SIGNATURE OF PARENT/PARENTS OR GUARDIAN(S) _____

SIGNATURE OF STUDENT OVER AGE 21: _____



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STUDENT MEDICAL HISTORY: TO BE COMPLETED BY A PHYSICIAN

NAME: _____ DATE: _____ PHONE: _____

Age: _____ Date of Birth: _____ Sex: _____ Height: _____ Weight: _____

Physically Handicapped: YES _____ NO _____ Mentally Retarded: YES _____ NO _____

Emotionally Disturbed: YES _____ NO _____ Learning Disabled: YES _____ NO _____

DIAGNOSIS: _____

Cause: _____ Onset: _____

Limbs affected: _____

If spinal cord involvement, what vertebral level: _____

If Downs Syndrome, Atlanto-Axial subluxation? Yes _____ No _____

Cervical x-ray for Atlanto-Axial subluxation: Positive _____ Negative _____

Estimate of mental ability: _____

Please indicate if the student has any of the following secondary problems by checking yes or no. If yes, please include complete information pertaining to the problem.

PROBLEM	YES	NO	If yes, describe
VISUAL			
HEARING			
SPEECH			
CARDIAC			
			Pulse: _____ Blood Pressure: _____
CIRCULATORY			
Peripheral Vascular Dis.			
Hemophilia			
PULMONARY			
METABOLIC/G.I. G.U.			
Diabetes			
Bladder/Bowel control			
SKIN and SOFT TISSUE			
Pressure sore			Healed (Yes No) Location _____
SURGERY			Date: _____
PAIN			
MEDICATION			





MEDICAL HISTORY

PROBLEM	YES	NO	If yes, describe
NEUROLOGICAL			
Seizures			Controlled (Yes No) Last Seizure
			Type
Hydrocephalus			Shunt (Yes No)
Sensory Loss			
MUSCULAR			
Contractures			
SKELETAL			
Subluxing hips			
Dislocating hips			
Spinal Lam inectomy			
Scoliois			Degree, type, last x-ray
Kyphosis, Lordosis			Degree, type
Spondylosis			
Spondylolisthesis			
Osteoporosis			
Heterotrophic Ossific			
Arthrodesis			
Fractures			Healed (Yes No) Location

OTHER or SPECIAL PRECAUTIONS _____

MOBILITY STATUS:

Can the student ambulate? Yes ____ No ____

Assistance: Independent ____ Minimal ____ Moderate ____ Maximal ____

1 person assist ____ 2 person assist ____

Physical aids: Canes ____ Crutches ____ Walker ____ Rolling Walker ____

Braces (type) _____

Other (ie. splints) describe _____

Does the student use a wheelchair? Yes ____ No ____ Type of w/c _____

Can the student propel the wheelchair? _____

Please describe any other additional information that might help us to work with this student. Thank you for your time.

Physician's Signature : _____ M.D. Date _____

Physician's Name (please print): _____ Phone: _____



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PHYSICIAN'S AUTHORIZATION

Student's Name: _____ Phone: _____

Authorization for Therapeutic Horseback Riding. Authorization, where appropriate, for evaluation and treatment by a Physical, Occupational, and/or Speech Therapist.

Recommended Frequency:

1 time per week _____

2 times per week _____

3 times per week _____

4 times per week _____

5 times per week _____



Precautions

Physician's Signature: _____ M.D. Date: _____

Physician's Name (please print) _____

Address: _____

ZIP _____

Phone: _____





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THERAPY ASSESSMENT

Name _____ Age _____ Date _____

Disability _____

Physical or Occupational Therapist _____

Address _____ ZIP _____

Phone - Home _____ Work _____

Evaluation Summary _____

Goals _____

Suggested Mounting Procedure _____

Precautions and/or Restrictions _____

Other comments _____

