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 _____

Street Address _____

City: _____ State: _____ Zip: _____ County: _____

Parent/Legal Guardian _____Phone_____

Parent email (please print): _____

Parent 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 ❑	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 hip 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)

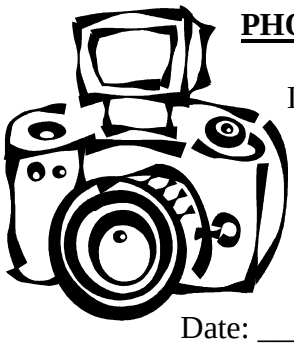

PHOTO RELEASE: OPTIONAL

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 Laminectomy			
Scoliosis			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: _____

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: _____

Physician's email (please print): _____

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THERAPY ASSESSMENT

Name _____ Age _____ Date _____

Disability _____

Physical or Occupational Therapist _____

Address _____ZIP_____

Phone - Home _____Work_____

Email (please print): _____

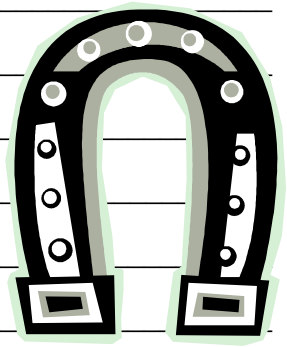
Evaluation Summary _____

_____

_____

_____

_____



Goals _____

_____

_____

_____

_____

Suggested Mounting Procedure _____

_____

Precautions and/or Restrictions _____

_____

_____

Other comments _____

_____

_____