P.O. Box 13155 Lexington, Kentucky 40511
(859) 231-7066
www.ckrh.org
A Therapeutic Experience

Year: 2016

Participant Registration – All Programming
Must be completed annually
Contact Information and Photo Release

I am a patient with Cardinal Hill and will schedule Hippotherapy through Cardinal Hill. Yes ____ No ____

I am a new participant _____ I am a returning participant _____ Date of last participation: _____

Participant's Name: _____

Age:_____ Date of Birth: _____ Employer or School: _____

Address: _____

City/State/Zip: _____ Email: _____

Home phone: _____ Cell phone: _____

Parent/Guardian/Caregiver: (Only need to complete if different than above.)

Name: _____

Address: _____ City/State/Zip: _____

Home phone: _____ Cell phone: _____ Email: _____

Employer:_____ Phone: _____

I hereby consent for the above information to be maintained in the CKRH database so that I may receive information about the program.

SIGNATURE: _____ **Date:** _____

____ I DO ____ I DO NOT consent to and authorize the use and reproduction by Central Kentucky Riding for Hope, Inc. of any and all photographs and any other audio-visual materials taken of me for promotional material, educational activities, exhibits, electronic publications (including World Wide Web) or for any other use for the benefit of the program.

SIGNATURE: _____ **Date:** _____

Goals: (Why are you applying for participation? What would you like to accomplish?)

_____

_____

_____

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Liability Release and Emergency Medical Information

Liability Release

_____ (Participant's Name) would like to participate in the Central Kentucky Riding for Hope, Inc. program. I acknowledge the risks and potential for risks of horseback riding, hippotherapy and horse related activities & therapies. 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, known or unknown whether existing on the date of agreement or in the future, against Central Kentucky Riding for Hope, Inc. and The Kentucky Horse Park, their Board of Directors, Employees, Instructors, Therapists, Aides, Volunteers, Equines, Equine Owners, Equipment and Operating Site for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating at Central Kentucky Riding for Hope, Inc.

"WARNING: Under Kentucky law, a farm animal activity sponsor, farm animal professional or other person does not have the duty to eliminate all risks of injury of participation in farm animal activities. There are inherent risks of injury that you voluntarily accept if you participate in farm animal activities."

SIGNATURE: _____ **Date:** _____

Emergency Medical Information

Name: _____

Physician's Name: _____

Preferred Medical Facility: _____

Health Insurance Company: _____

Policy #: _____

Known Allergies including medications: _____

_____

Current Medication: _____

I would want emergency responders to know: _____

_____

Person(s) to be contacted in case of an emergency: (Must list two contacts.)

1. Name: _____ Relation: _____ Phone: _____

2. Name: _____ Relation: _____ Phone: _____

3. Name: _____ Relation: _____ Phone: _____

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Participant Medical History

Diagnosis: _____ Date of Onset: _____

Seizures: ____ Type: _____ Controlled: Yes ____ No ____ Date of last seizure: _____

Current Height: _____ Current Weight: _____ Date of last Tetanus Shot: _____

Shunt present? Yes ____ No ____ Date of last revision: _____ Info: _____

Medications: _____

Please indicate current or past special needs, concerns and/or surgeries in any of the following areas by typing an X beside yes or no. If yes, please comment.

____ Y ____ N Auditory: _____
____ Y ____ N Visual: _____
____ Y ____ N Tactile Sensation _____
____ Y ____ N Speech: _____
____ Y ____ N Cardiac: _____
____ Y ____ N Circulatory: _____
____ Y ____ N Integumentary/Skin: _____
____ Y ____ N Digestion: _____
____ Y ____ N Elimination: _____
____ Y ____ N Immunity: _____
____ Y ____ N Pulmonary: _____
____ Y ____ N Neurological: _____
____ Y ____ N Muscular: _____
____ Y ____ N Balance: _____
____ Y ____ N Orthopedic: _____
____ Y ____ N **Allergies**: _____
____ Y ____ N Learning Disability: _____
____ Y ____ N Cognitive: _____
____ Y ____ N Emotional/Psychological: _____
____ Y ____ N Behavioral: _____
____ Y ____ N Pain: _____
____ Y ____ N Other: _____

Describe Mobility, ie independent ambulation, assisted ambulation, wheelchair, braces: _____

_____

Additional Medical Information: _____

To the best of my knowledge the medical history is true and accurate:

SIGNATURE: _____ **Date:** _____

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Physician's Medical Form – Must be completed by physician's office.

Dear Health Care Provider:

Your patient, _____ is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete this 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. If you have any questions or concerns regarding this patient's participation in therapeutic horseback riding, hippotherapy and horse related activities, please do not hesitate to contact the operating center at the address/phone indicated.

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

Patient weight during last exam _____ Date of exam _____ Height _____ Diagnosis _____

Orthopedic

Spinal Joint Fusion: Y N _____
Spinal Joint Instabilities/Abnormalities: Y N _____
_____
Scoliosis: Y N _____
Kyphosis: Y N _____
Lordosis: Y N _____
Hip/Joint Subluxation and Dislocation: Y N
_____
Osteoporosis: Y N _____
Pathologic Fractures: Y N _____
Coxas Arthrosis: Y N _____
Heterotopic Ossification: Y N _____
Osteogenesis Imperfecta: Y N _____
Cranial Deficits: Y N _____
Spinal Orthoses: Y N _____
Internal Spinal Stabilization Devices: Y N _____
_____

Neurological

Hydrocephalus/shunt: Y N _____
Spina Bifida: Y N _____
% Curvature: _____
Paralysis due to Spinal Cord Injury: Y N _____
Chiari II Malformation: Y N _____
Hydromyelia: Y N _____
Tethered Cord: Y N _____
Seizure Disorders: Y N _____
Type: _____

Medical/Surgical

Allergies: Y N _____
Recent Surgery: Y N _____
Explain: _____
Cancer: Y N _____
Diabetes: Y N
Peripheral Vascular Disease: Y N _____
Varicose Veins: Y N _____
Poor Endurance: Y N _____
Hemophilia: Y N _____
Hypertension: Y N _____
Serious Heart Condition: Y N _____
Explain: _____
Stroke (Cerebrovascular Accident): Y N _____

Secondary Concerns:

Indwelling catheter: Y N _____
Behavior problems: Y N _____
Weight control disorder: Y N _____
Thought control disorder: Y N _____
Substance Abuse: Y N _____
Danger to self or others: Y N _____

Physician's Statement

Given the diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the PATH, Intl. center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH, Intl. center for ongoing evaluation to determine eligibility for participation.

Physician's name /title (please print): _____

License/UPIN Number: _____ MD DO NP PA other_____

Address: _____ Phone: _____

Physician's Signature: _____ Date: _____

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Demographic Information

Central Kentucky Riding for Hope is a non-profit organization supported by donations. We are frequently required to provide anonymous demographic information when applying for grants and other funding. Your help is greatly needed. Every participant must complete the following information. This information **will be kept confidential** and you may return this page separate from other registration information.

Please remember that participant fees cover a very small percentage of the cost to provide service. An important way you can help with fundraising is to provide CKRH with needed information to apply for grants and funding.

DOB: _____ Age:_____ Male: _____ Female: _____

Kentucky County of Residence: _____

How did you hear about the program? _____

Diagnosis: _____

How long has the participant been coming to *CKRH*? _____

What is your relationship to the participant? (please circle)
____ Self ____ Parent ____ Spouse ____ Aide ____ Guardian

How many people live in the home with the participant? _____
Of this number, how many are under age 19 _____

What is the total annual income of the household? (please type an x beside one)

____ Less than $15,000
____ Between $15,000 – $26,150
____ Between $26,150 – $29,500
____ Between $29,500- $33,600
____ Between $33,600 - $37,350
____ Between $37,350 - $40,350
____ Between $40,350 - $43,350
____ Between $43,350 - $46,300
____ Between $ 46,300 - $50,000
____ Between $ 50,000 - $75,000
____ Between $75,000 - $100,000
____ Above $100,000

Occupation of Self, Parents or Guardians (optional) _____

Please indicate the participant's ethnicity (needed for grant applications).
____ White/Caucasian ____ Hispanic Origin ____ Mixed- Please explain:
____ Asian/Pacific Islander ____ American Indian _____
____ African American ____ Other _____ _____

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Rider Weight Policy

CKRH will adhere to the following guidelines when making decisions regarding rider weight. Each guideline is in place so that every member of the team (horse, rider and volunteer) may have a safe experience. Horse health, rider's weight distribution, rider's ability to dismount without hurting the horse and each volunteer's ability to safely assist a rider are all very important considerations.

- Each horse will be evaluated as an individual and assigned a maximum carrying weight. Considerations will be made for age and health/soundness.
- Each rider will be evaluated as an individual. Considerations will be made for rider's height, range of motion, balance and ability to dismount independently.
- Each team will be evaluated to ensure that an appropriate volunteer/instructor is available to complete all emergency procedures including an emergency dismount.
- In general the following rider height to weight ratios will be followed.

Rider Height	Maximum Weight
Under 5'0 tall	150 lbs
5' to 5'6 tall	175 lbs
5'7 to 6' tall	200 lbs
6'1 to 6'5 tall	250 lbs

- The maximum amount of weight each horse can carry is determined using the following formula:
    - 20% of the horse's weight minus the weight of tack minus 10 pounds for degrees of unbalanced rider movement. (Unbalanced rider movement is determined through instructor observation while rider is mounted and through a balance exam while non-mounted.) Other considerations are observation of equine movement while carrying weight and veterinary input.
- Each horse has a maximum number of lessons they may participate in per week. Therefore the number of horses available to carry higher weights may be limited.
- If, after an evaluation by at least two CKRH staff members, a rider is determined to be over the weight limit of any available CKRH horse, the participant has the option to participate in other CKRH programs such as therapeutic carriage driving and therapeutic horsemanship.

Riders may be asked to weigh-in on CKRH scales at any point during their riding sessions.