



RIDER APPLICATION PACKET

Date of Application: _____

Participant Name (First/Last): _____ Gender: M / F

DOB: _____ Age: _____ Height: _____ Weight: _____

Address _____ City _____ Zip _____

Phone (H) _____ (C) _____ (W) _____

Email: _____

Parent/Guardian (1): _____ Relationship: _____

Address (if different from above): _____ City _____ Zip _____

Phone(H) _____ (C) _____ (W) _____

Email: _____

Parent/Guardian (2): _____ Relationship: _____

Address (if different from above): _____ City _____ Zip _____

Phone(H) _____ (C) _____ (W) _____

Email: _____

Caregiver (if applicable): _____

Caregiver contact (phone): _____

How did you hear about our program? _____

Scheduling/Availability

Who to contact for scheduling? _____

Phone # _____



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Participant Availability? (check all days times that you are available)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8-9am	n/a	n/a	n/a	n/a	n/a	n/a	
9-10am	n/a					n/a	
10-11am	n/a					n/a	
11-12pm	n/a					n/a	
1-2pm	n/a					n/a	
2-3pm	n/a					n/a	
3-4pm	n/a					n/a	

Other: indicate days and times available _____

Who will be attending the lesson with the student? _____

Health History Questionnaire

Participant Name: _____

Diagnosis: _____ Date of onset: _____

Tetanus shot: Y / N Date of last shot: _____

Any specific precautions or contraindications that the instructor needs to be aware of? _____

Goals you'd like the participant to accomplish with the program: _____



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To help us better prepare, please indicate any special needs required in the following areas:

Does the participant...?	Yes	No	Explain
Walk independently?			
Have mobility/ range of motion issues?			
Have poor balance, sitting/standing?			
Have auditory issues?			
Have speech/ language difficulties?			
Have vision issues?			
Have heart/circulation problems?			
Have breathing problems?			
Have pain?			
Have orthopedic problems?			
Have seizure disorders?			
Have neurological problems?			
Have behavioral problems/concerns?			
Have problems following instructions?			
Have Down Syndrome?			If yes, special medical release is required from M.D.
Other:			

Other pertinent medical or behavioral information that may be helpful: _____

Medications: _____



THERAPEUTIC RIDING PROGRAM POLICIES AND REQUIREMENTS

General

- Must be a minimum of 4 years old
- Participants must complete ALL paperwork prior to their initial lesson.
- either a parent or caretaker needs to present at the lesson, and on-hand (not in their car), to assist during lessons with any cognitive or unforeseen issues that may arise as they are most familiar with how to calm or intercede with the student as needed.
- Must provide an annual referral from a qualified doctor if there is a physical condition or diagnosis.
- For riders with Down syndrome: no signs of atlantoaxial instability with MD sign off.
- For those with non physical needs, a referral can be completed by a licensed specialist such as a PT, social worker, behavioral specialist, special education teacher, etc.
- Able to abide by all required safety rules and protocols while on the property and in class.
- CPR reserves the right to refuse any rider based on our ability to safely accommodate his/her needs. Additionally, we may provide other non mounted horsemanship activities if there are any safety concerns for the participant, instructor, equine or volunteers.

Cancellation/ Attendance Policy

- The program requests a minimum 24 hour notice for cancellations for the purpose of staff/ volunteer scheduling adjustments.. If you know a rider cannot attend a future lesson, advise us by text or phone call as soon as possible. Any lesson cancellations made within the 24 hour time frame or “no-shows” will be charged the full amount of the lesson.
- In the event you need to cancel a lesson, please call or text **Jessica York at 619/672-8867** if it’s within 48 hours, for cancellations more than 48 hours you can email us at: **cougarpassrecovery@gmail.com**
- For students arriving more than 15 minutes late for lessons, the instructor may modify the lesson as they see fit, which may mean ground work only due to the time constraints. After 3 no shows or tardies the instructor may choose to offer your time slot to another rider if it’s a requested time.
- In the case of inclement conditions (rain, high wind, heat, environmental hazards, etc.) and mounted lessons cannot safely be performed, a horsemanship lesson will replace the mounted lesson which may also include grooming, tack identification, and other skill building instruction. If a client chooses not to attend a horsemanship lesson no make-up, refund or credit will be provided.
- **All payments must be made prior to your lesson. We accept cash, check or PayPal** (which includes credit or debit card if you don’t have an account with them).

I have read and understand the above program policies and agree to abide by them.

Signature: _____ Date: _____

Name (printed): _____



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AUTHORIZATION FOR MEDICAL TREATMENT

In the event emergency treatment/medical aid is required due to illness or injury during a therapeutic riding session, or while being on the property of CPR/Miller Equestrian Services or in connection with, I authorize Cougar Pass Recovery Ranch and/or its representatives 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.

This authorization includes x-ray, surgery, hospitalization and any treatment procedure deemed necessary by the physician for the participant listed below:

Name of Participant: _____
Address/City/State/Zip: _____
Phone: _____ DOB: _____
Current Diagnosis (if applicable) _____
Allergies: _____
Date of Last Tetanus Shot: _____
Medications or Any special instructions: _____

If participant is a minor or has a legal guardian, please list emergency contact information:

Emergency Contact#1: _____ Relationship: _____
Phone (C) _____ (H) _____ (W) _____

Emergency contact #2: _____ Relationship: _____
Phone (C) _____ (H) _____ (W) _____

I give my consent for Emergency Medical Treatment as indicated above:

Consent Signature: _____ Date: _____
Print Name: _____ Relationship: _____



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PHYSICIAN REFERRAL FORM

Participant Name: _____ DOB: _____

The above participant is interested in participating in supervised equine activities, including horseback riding at Cougar Pass Recovery Ranch. In order to safely provide these activities, we ask for a physician release.

For Persons with Down Syndrome:

Negative Cervical x-ray for Atlantoaxial Instability? Y / N X-ray date _____

Evidence of neurologic symptoms of AtlantoAxial Instability present? Y / N Date: _____

Precautions/Contraindications

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, if so, to what degree.

Check Box if condition is present and please provide more details in comments.

Orthopedic	Comments
<input type="checkbox"/> Spinal Fusion	
<input type="checkbox"/> Spinal Instabilities/Abnormalities	
<input type="checkbox"/> Atlantoaxial Instabilities	
<input type="checkbox"/> Scoliosis/ Kyphosis/ Lordosis	
<input type="checkbox"/> Hip Subluxation and Dislocation	
<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Pathologic Fractures	
<input type="checkbox"/> Coxas Arthrosis	
<input type="checkbox"/> Heterotopic Ossification	
<input type="checkbox"/> Osteogenesis Imperfecta	
<input type="checkbox"/> Cranial Deficits	
<input type="checkbox"/> Spinal Orthoses	
<input type="checkbox"/> Internal Spinal Stabilization Devices	
<input type="checkbox"/> NONE OF THE ABOVE	

Neurologic	Comments
<input type="checkbox"/> Hydrocephalus/shunt	
<input type="checkbox"/> Spina Bifida/ Tethered Cord	
<input type="checkbox"/> Chiari II Malformation	
<input type="checkbox"/> Paralysis due to Spinal Cord injury	
<input type="checkbox"/> Seizure Disorders	



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NONE OF THE ABOVE

Medical/Surgical	Comments
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- Allergies
- Cancer
- Poor Endurance
- Recent Surgery
- Diabetes
- Peripheral Vascular Disease
- Varicose Veins
- Hemophilia
- Hypertension
- Serious Heart Condition
- Stroke (Cerebrovascular Accident)
- NONE OF THE ABOVE

Physician Release

Given the current diagnosis and medical information, to my knowledge, there is no reason why this individual cannot participate in supervised equestrian activities, including riding a horse. I understand that CPR will weigh the medical information provided against the existing precautions and contraindications to determine eligibility for participation.

Diagnosis: _____ Date of Onset: _____

Physician Name (print): _____

Physician Signature: _____ Date: _____

Title: MD / DO: License/UPIN#: _____

Address: _____

Office Phone # _____

Please return completed form via mail or email to Cougar Pass Recovery Ranch (see below for address) or return to the requested party.