

## **Therapeutic Riding of the Ozarks Equine Assisted Therapy**

### **Enrollment Packet**

Therapeutic Riding of the Ozarks (TRO) currently operates two riding sessions per year at MSU's Darr Agriculture Center, one each spring and fall. TRO also operates its summer and hippo therapy sessions at the Cheesman Farm in Republic, MO. Sessions are a total of six or eight one-hour lessons. Enrollment packets for TRO are mailed out several weeks prior to the start of the session, and as requested. This is to allow you time to get the forms completed by the session application deadline. All forms are valid for one year from the date they are completed. Once you have mailed back the completed application, the TRO Director, NARHA certified instructors, physical therapy, occupational therapy, and equine professionals will review it. You will be notified prior to the start of the session if your rider has been accepted and of the lesson time, or if your rider has been placed on the waiting list.

### **Enrollment Process**

- 1) Applications are mailed to the families and guardians of all interested clients.
- 2) Applications must be returned by the deadline indicated.
- 3) Program admission decisions are based on the information contained in the application packet and NARHA standards.
- 4) No more than 25 riders will be admitted each session.
- 5) Riders are grouped in lessons based on abilities and therapy goals.
- 6) Parents/Guardians will be notified that their rider has or has not been admitted to the program.
- 7) Parents/Guardians will be notified of their rider's lesson time at least one week prior to the first day of lessons.

### **Application Packet**

The following forms must be completed for each rider:

- Medical Release
- Rider Liability Release
- Photo Release
- Physical Therapist or Occupational Therapist Evaluation
- Physician's Permission

### **Safety Considerations**

- Your rider needs to wear long pants
- Your rider must wear a helmet at all times in the arena
- Your rider must wear close-toed shoes, preferably with a ½ inch heel
- Please do not allow children to climb on the gates or fence of the arena
- Ask before petting any horse in the barn. Not all the horses that will be in the barn have the temperament of the therapy horses.

## Therapeutic Riding of the Ozarks

### Medical Release

Date \_\_\_\_\_

Rider Name \_\_\_\_\_ DOB \_\_\_\_\_

Parent(s)/Guardian(s) \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone: Home

\_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

E-mail \_\_\_\_\_

Rider Diagnosis/Disability \_\_\_\_\_

Date of Onset of Disability \_\_\_\_\_

Does the Rider receive Speech Therapy services? Yes No

Does the rider use a communication device? Yes No What type? \_\_\_\_\_

Please let us know if there is anything in particular that you would like us to know regarding the riders' communication. \_\_\_\_\_

\_\_\_\_\_

Rider Height \_\_\_\_\_ Rider Weight \_\_\_\_\_ Rider T-shirt size \_\_\_\_\_

Does the rider have any previous experience with horses? Explain: \_\_\_\_\_

\_\_\_\_\_

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Person(s) authorized to give temporary assistance or care in the absence of parent or guardian:

\_\_\_\_\_

Preferred Medical Facility \_\_\_\_\_

Describe any medical condition requiring special precautions or treatment, and any medications and dosage \_\_\_\_\_

\_\_\_\_\_

In case of medical emergency, the undersigned authorizes \_\_\_\_\_  
to provide such medical assistance as they determine to be necessary.

The undersigned authorizes any licensed physician and/or medical facility to provide any medical/surgical care and/or hospitalization for the rider, including anesthetic, which they determine necessary or advisable, pending receipt of a special consent form from the undersigned.

No person can be accepted for riding instruction until the parent(s) or guardian has completed this form. If the person is of legal age (18) he or she may complete the form, if he or she is legally competent to do so. Riding instruction will be under strict supervision, and although every effort will be made to avoid any accident, **NO LIABILITY** can be accepted by any of the organizations concerned, including but not limited to: The Council of Churches of the Ozarks, Therapeutic Riding of the Ozarks, Missouri State University, Cheesman Farm, Greene County Board for the Developmentally Disabled, Boys & Girls Town of Missouri, and Burrell Behavioral Health.

Yes I would like \_\_\_\_\_ to have riding instruction, and I have discussed this with the rider's physician. I understand that **NO LIABILITY** can be accepted by any organizations concerned with this instruction in the event of any accident that may occur.

\_\_\_\_\_  
*Signature of Parent(s) or Guardian* Date \_\_\_\_\_

\_\_\_\_\_  
*Printed Name of Parent(s) or Guardian* Date \_\_\_\_\_

\_\_\_\_\_  
*Signature of Rider if Over Age 18* Date \_\_\_\_\_

## *Therapeutic Riding of the Ozarks*

An operating agency of Council of Churches of the Ozarks

### Liability Release

#### WARNING

Under Missouri law, 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 pursuant to the Revised Statutes of Missouri. Section A Chapter 537.325

As a participant/volunteer/staff member of Therapeutic Riding of the Ozarks, an operating agency of Council of Churches of the Ozarks, I acknowledge the risks and potential risks of a horseback riding program. However, I feel that the possible benefits are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever, acquit, discharge and hold harmless the ***Council of Churches of the Ozarks, Therapeutic Riding of the Ozarks, Missouri State University, Cheesman Farm, Boys & Girls Town of Missouri, and Burrell Behavioral Health***, its officers, trustees, agents, employees, representatives, successors and assigns, for all manner of claims, demands and damages of every kind and nature whatsoever, which the undersigned or said minor may now, or in the future, have against the ***Council of Churches of the Ozarks, Therapeutic Riding of the Ozarks, Missouri State University, Cheesman Farm, Boys & Girls Town of Missouri, and Burrell Behavioral Health***, its officers, trustees, agents, employees, representatives, successors or assigns on account of any personal injuries, physical or mental condition, known or unknown, to the person of said minor and the treatment therefore as a result of, or in any way growing out of, the acts of the ***Council of Churches of the Ozarks, Therapeutic Riding of the Ozarks, Missouri State University, Cheesman Farm, Boys & Girls Town of Missouri, and Burrell Behavioral Health***, its officers, trustees, agents, employees, representatives, successors or assigns, including, but not limited to, their negligence or gross negligence, in rendering the services above described or in any way incidental thereto.

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Parent or Legal Guardian if under 18)

## Therapeutic Riding of the Ozarks

### Photo Release Form

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grant to ***Council of Churches of the Ozarks, Therapeutic Riding of the Ozarks, Missouri State University, Cheesman Farm, Boys & Girls Town of Missouri, and Burrell Behavioral Health***, permission to take or have taken, still and moving photographs and films including television pictures of \_\_\_\_\_ and consents and authorizes ***Council of Churches of the Ozarks***, its advertising agencies, news media, and any other persons interested in ***Council of Churches of the Ozarks, Therapeutic Riding of the Ozarks, Missouri State University, Cheesman Farm, Boys & Girls Town of Missouri, and Burrell Behavioral Health***, and its work, to the use and reproduction of the photographs, films, and pictures to circulate and publicize the same by all means including without limit, the generality of the foregoing newspapers, television media, brochures, pamphlets, instructional materials, books and clinical material.

With regard to the foregoing material, no inducements or promises have been made to us/me to secure our/my signature(s) to this release other than the intention of ***Council of Churches of the Ozarks, Therapeutic Riding of the Ozarks, Missouri State University, Cheesman Farm, Boys & Girls Town of Missouri, and Burrell Behavioral Health*** to use or be used such photographs, films and pictures for the primary purpose of promoting and aiding its program and its work.

\_\_\_\_\_  
Signature of Parent(s) or Guardian

Date \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Parent(s) or Guardian

Date \_\_\_\_\_

**Therapeutic Riding of the Ozarks**  
**Physical Therapy or Occupational Therapy Evaluation**

Evaluation Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ DOB \_\_\_\_\_

Primary Diagnosis \_\_\_\_\_

Description \_\_\_\_\_

\_\_\_\_\_

Surgeries Performed (including dates)

\_\_\_\_\_

\_\_\_\_\_

Other Relevant Medical History

\_\_\_\_\_

\_\_\_\_\_

**Pain:**

Character \_\_\_\_\_

Location \_\_\_\_\_

Caused By \_\_\_\_\_

Relieved By \_\_\_\_\_

**Functional Abilities:**

Mobility \_\_\_\_\_

Transfers \_\_\_\_\_

ADL Skills \_\_\_\_\_

**Muscle Strength:**

Gross \_\_\_\_\_

Specific Weaknesses \_\_\_\_\_

**Joint ROM:**

Gross \_\_\_\_\_

Specific Limitations \_\_\_\_\_

**Muscle Tone** \_\_\_\_\_

**Trunk Strength:**

Torso-Prone Extension \_\_\_\_\_

Supine Flexion \_\_\_\_\_

Scapular Stability \_\_\_\_\_

**Balance:**

Sitting \_\_\_\_\_

Standing \_\_\_\_\_

**Developmental Balance-Protective Reactions:**

Forward \_\_\_\_\_

Backward \_\_\_\_\_

R Side \_\_\_\_\_

L Side \_\_\_\_\_

**Coordination:**

Gross Motor \_\_\_\_\_

Fine Motor \_\_\_\_\_

**Reflex Activity:**

Developmental \_\_\_\_\_

Tendon Reflexes \_\_\_\_\_

ATNR \_\_\_\_\_

STNR \_\_\_\_\_

Cross Extension \_\_\_\_\_

Other \_\_\_\_\_

**Motor Planning:**

Diadokinesis \_\_\_\_\_

Rapid Hand Rotation \_\_\_\_\_

Finger Opposition \_\_\_\_\_

Imitation of Postures \_\_\_\_\_

**Bilateral Hand Usage:**

Simultaneously \_\_\_\_\_

Separately \_\_\_\_\_

Midline Crossing \_\_\_\_\_

Dominance in: Hand \_\_\_\_\_ Eye \_\_\_\_\_ Foot \_\_\_\_\_

**Grasps:**

Right

Left

Rake \_\_\_\_\_

3 Finger \_\_\_\_\_

Pincer \_\_\_\_\_

Key \_\_\_\_\_

**Olfactory** (Parent Report) \_\_\_\_\_

**Auditory** (Parent Report) \_\_\_\_\_

**Visual Motor-Tracking** \_\_\_\_\_

**Visual Perception:**

MVPT Figure Ground \_\_\_\_\_  
Position in Space \_\_\_\_\_  
Visual Memory \_\_\_\_\_  
Visual Closure \_\_\_\_\_  
Spatial Relationships \_\_\_\_\_

**Sensory Impairments** \_\_\_\_\_  
**Perceptual Problems** \_\_\_\_\_  
**Communication Difficulties** \_\_\_\_\_  
**Skin Condition(s)** \_\_\_\_\_

**Problem List:**

**Plans and Goals:**

- 1. \_\_\_\_\_  
\_\_\_\_\_
- 2. \_\_\_\_\_  
\_\_\_\_\_
- 3. \_\_\_\_\_  
\_\_\_\_\_
- 4. \_\_\_\_\_  
\_\_\_\_\_
- 5. \_\_\_\_\_  
\_\_\_\_\_

**Additional Comments:**

\_\_\_\_\_ Date \_\_\_\_\_  
*Printed Name of Physical Therapist or Occupational Therapist*

\_\_\_\_\_ Date \_\_\_\_\_  
*Signature of Physical Therapist or Occupational Therapist*

**Therapeutic Riding of the Ozarks**  
**Physician Permission**

Date: \_\_\_\_\_  
Client Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_  
Client DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_  
Date of Onset: \_\_\_\_\_

*Therapeutic Riding of the Ozarks (TRO)* is a therapeutic horseback-riding program designed to benefit the riders physically, socially, and emotionally. Safety equipment and specially trained horses and volunteers are used. In order to assure the fullest possible protection and greatest personal benefit from the program, each rider is required to furnish the following medical information before being accepted as a rider.

**NOTE:** Because of the nature of the activity of horseback riding, no individual diagnosed with Down's Syndrome can be accepted for riding instruction without proof of a negative diagnostic x-ray for Atlantoaxial Dislocation Condition.

- If the diagnosis is Down's Syndrome, this form must be accompanied by one of the following:**
- a. Special Olympic Down Syndrome Athletic Evaluation**
  - b. Signed, dated statement from a qualified physician giving the date and result of a diagnostic x-ray for Atlantoaxial Dislocation Condition.**

Medical History: \_\_\_\_\_  
\_\_\_\_\_

Surgical Procedures: \_\_\_\_\_  
\_\_\_\_\_

Medications: \_\_\_\_\_ For: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Defects present in:

- Sight \_\_\_\_\_
- Hearing \_\_\_\_\_
- Speech \_\_\_\_\_
- Neuro-sensation \_\_\_\_\_
- Balance \_\_\_\_\_
- Mobility \_\_\_\_\_
- Coordination \_\_\_\_\_
- Muscle Tone \_\_\_\_\_

Are braces or other assistive devices used? \_\_\_\_\_

Is the client ambulatory? *Please circle* Yes or No

Seizure Type \_\_\_\_\_

Are the seizures controlled? *Please circle* Yes or No or NA

Date of Last Seizure \_\_\_\_\_

Is there a Shunt Present? *Please circle* Yes or No

Date of Last Revision \_\_\_\_\_

Is the client: Continent or Incontinent?

General Comments: \_\_\_\_\_  
\_\_\_\_\_

**IN MY OPINION THE ABOVE NAMED CLIENT MAY RECEIVE THERAPEUTIC HORSEBACK RIDING INSTRUCTION UNDER APPROPRIATE SUPERVISION.**

Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**\*This form is valid for a period of one year from the date signed. \***

