EQUESTRIA® AFTER-SCHOOL THERAPEUTIC RIDING PROGRAM FOR CHILDREN WITH SPECIAL NEEDS

Dear Parent :

Thank you for your interest in having your child participate in the EQUESTRIA® Therapeutic Riding Program For Children With Special Needs.

Enclosed with this letter you will find 3 forms.

Please fill out the forms titled :

1/ Questionnaire for parents who would like their child to be a student in the EQUESTRIA Therapeutic Riding Program For Children With Special Needs

2/ New York Therapeutic Riding Center Registration and Release Form

Please have your child's Physician fill out the form titled :

Rider's Medical History and Physician's Statement

If you need assistance in filling out these forms, call or email the Equestria Administrative Offices at the below provided phone number or email address

In addition to these forms, please provide :

1/ A letter stating why you believe the EQUESTRIA Therapeutic Riding Program would be beneficial to your child

2/ A photograph of your child

VERY IMPORTANT :

Please mail by USPS completed forms along with your letter and child's photograph to:

New York Therapeutic Riding Center
336 East 71 Street / 3D, New York, NY 10021

To call us or send by Fax : (212) 535-3917

To send by email : programinfo@equestria.nyc

Please keep a copy of your completed forms, your letter and all support materials for your records

Questionnaire for parents who would like their child to be a student in the Equestria® Therapeutic Riding Program For Children With Special Needs

(PLEASE PRINT)

1/ A: Name Of Child :_____

B: Name(s) Of Parent(s) :_____

2/ Address (*Street / City / State / ZIP*) :_____

_____

3/ Tel. Numbers : Home : (_____)_____-_____ Work : (_____)_____-_____

Cell : (_____)_____-_____ Email :_____

4/ Age Of Child :_____ Child's Date Of Birth :_____/_____/_____

5/ Sex Of Child : Male ☐ | Female ☐

6/ Weight Of Child : _____lbs _____oz Height Of Child :_____ft _____in

7/ A: Primary Disability Of Child : _____

B : Secondary Disability Of Child :_____

8/ Can your child walk independently : Yes ☐ No ☐

9/ Mobility aids needed by your child : A/ Wheelchair ☐ B/ Crutches ☐

C/ Cane ☐ D/ None ☐

10/ If your child uses a wheelchair, does the child have sufficient sitting balance out of the wheelchair to sit independently?... on a bench? Yes ☐ No ☐

If your child uses a wheelchair, does the child stand independently, i.e. without assistance, for a minute or so? Yes ☐ No ☐

11/ Is your child verbal? Yes ☐ No ☐

If no, is child learning sign language? Yes ☐ No ☐

12/ A: Does your child have any allergies? Yes ☐ No ☐

B: If yes, what are the allergies? _____

C: Can the allergies be controlled by medication? Yes ☐ No ☐

13/ Is your child afraid of animals? Yes ☐ No ☐

14/ Types of sports, recreational activities that your child participates in :

A: In School :_____

B: After School :_____

15/ School attended by your child:

A: Name of school :_____

B: Address of School :_____

C: Telephone number of school :_____

D: Public School ☐ (or) Private School ☐

E: Times of the day that your child attends school:

(1) September - May :_____ **(2)** June - August :_____

Questionnaire for parents who would like their child to be a student in the Equestria® Therapeutic Riding Program For Children With Special Needs

(PLEASE PRINT)

16/ Does your child get : Physical Therapy: Yes ☐ No ☐
Occupational therapy : Yes ☐ No ☐

If "Yes" what is the name and telephone number of the child's :

A: Physical therapist : _____

B: Occupational therapist : _____

17/ Your Child's Physician :

A: Name : _____

B: Address (*Street / City / State / ZIP*) : _____

_____

C: Telephone Number : _(_____)_____-_____ **Fax :** _(_____)_____-_____

D: Specialty : _____

E: Hospital affiliation : _____

18/ A: Does your child have health insurance coverage : Yes ☐ No ☐

B: If "Yes", what is the name of the insurance company :

_____

C: Does your child receive Medicaid or SSI? Yes ☐ No ☐

19/ Does your child live in private housing ☐ or public housing? ☐

20/ Occupation of parent(s): _____

21/ Income level of parent(s) : A/ Under $30,00 ☐ B/ $30,000 - $60,000 ☐ C/ Over $60,000 ☐

22/ Medicaid Service Coordinator :

A/ Name of child's Medicaid Service Coordinator}: _____

B/ Medicaid Service Coordinator's rehabilitation agency and phone number : _____

_____

23/ In what ways do you think your child would benefit from participating in the Equestria Therapeutic Riding Program For Children With Special Needs?

_____

_____

24/ Who would bring your child to the Equestria Therapeutic Riding Program classes?

_____

25/ What type of transportation would be used for your child's travel to the Equestria Program?

Subway ☐ Bus ☐ Access-A-Ride ☐ Private Car ☐

_____

Signature Of Parent

_____

Date

THE NEW YORK THERAPEUTIC RIDING CENTER©
& EQUESTRIA THERAPEUTIC RIDING PROGRAM

Therapeutic Horseback Riding For People With Disabilities

Registration & Release Form

Registration

Name of Child :_____ Date of Birth : ___/__/____ Age:____

Name(s) of Parent(s) :_____

Address (Street/City/State/Zip) :_____

Tel. Numbers : Home Phone :_(_____)_____-_____ Work Phone :_(_____)_____-_____

Cell : _(_____)_____-_____ Email :_____

School or Institution Child is attending :_____

In case of emergency contact :_____Phone :_____

Alternate contact :_____ Phone :_____

Liability Release : Child's Name *(First)*_____ *(Last)* _____ would like to participate in the Equestria Therapeutic Riding Program For Children With Special Needs. I acknowledge the risks and potential of risks for horseback riding. However, I feel that the possible benefits to my child 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 the New York Therapeutic Riding Center, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses my child may sustain while participating in the Equestria Therapeutic Riding Program.

Date :_____ Signature :_____
Parent or Guardian

Audio/Visual/Video Release : I hereby consent to and authorize the use and reproduction by the New York Therapeutic Riding Center of any and all photographs and other audiovisual materials taken of my child, which would include : myself (wife/husband/support staff/relative), for promotional printed material (or Publication), web site, educational activities or for any other use for the benefit of the New York Therapeutic Riding Center and the Equestria Program.

Date :_____ Signature :_____
Parent or Guardian

EQUESTRIA AFTER-SCHOOL THERAPEUTIC RIDING PROGRAM©

Equestria® Therapeutic Riding Program For Children With Special Needs

Rider's Medical History and Physician's Statement

To be completed annually

Name:_____ Date of Birth:_____

Address:_____

Name of Parent/Guardian:_____

Diagnosis:_____ Date of Onset:_____

** *For Persons with Down Syndrome*

☐ Negative Cervical Xray for Atlantoaxial Instability Xray date:_____

☐ Negative for clinical symptoms of Atlantoaxial Instability

Tetinus Shot ☐ Yes ☐ No Date:_____ Height:_____ Weight:_____

Seizure Type:_____ Controlled:_____ Date of last seizure:_____

Medications:_____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking "Yes" or "No". If "Yes" please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility : Independent Ambulation ☐Yes ☐No Crutches ☐Yes ☐No Braces ☐Yes ☐No

Wheelchair ☐Yes ☐No Please indicate any special precautions:_____

_____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the New York Therapeutic Center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician Name (please print):_____

Physician Signature:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_(_____)_____-_____ Date:_____

Rider's Medical History and Physician's Statement

To be completed annually

Information for Physician

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

- ☐ Spinal Fusion
- ☐ Spinal Instabilities/Abnormalities
- ☐ Atlantoaxial Instabilities
- ☐ Scoliosis
- ☐ Kyphosis
- ☐ Lordosis
- ☐ Hip Subluxation and Dislocation
- ☐ Osteoporosis
- ☐ Pathologic Fractures
- ☐ Coxas Arthrosis
- ☐ Heterotopic Ossification
- ☐ Osteogenesis Imperfecta
- ☐ Cranial Deficits
- ☐ Spinal Orthoses
- ☐ Internal Spinal Stabilization Devices

Neurological

- ☐ Hydrocephalus/shunt
- ☐ Spina Bifida
- ☐ Tethered Cord
- ☐ Chiari II Malformation
- ☐ Hydromyelia
- ☐ Paralysis due to Spinal Cord Injury
- ☐ Seizure Disorders

Medical/Surgical

- ☐ Allergies
- ☐ Cancer
- ☐ Poor Endurance
- ☐ Recent Surgery
- ☐ Diabetes
- ☐ Peripheral Vascular Disease
- ☐ Varicose Veins
- ☐ Hemophilia
- ☐ Hypertension
- ☐ Serious Heart Condition
- ☐ Stroke (Cerebrovascular Accident)

Secondary Concerns

- ☐ Behavior problems
- ☐ Acute exacerbation of chronic disorder
- ☐ Indwelling catheter

Please provide relevant information for any of the conditions checked above:

_____

_____

_____

_____