P.O. Box 782622 Wichita, KS 67278
Phone: 316-733-8943

☐ NEW Start date: _____
☐ Returning
Orig. Date: _____
Return Date: _____
☐ Physician: Date: _____
☐ Emergency Authorization
Treat
No Treat
☐ Liability Release
☐ Photo: Yes No
☐ INITIAL:_____DATE: _____
Office Use Only

Student Application and Emergency Contact Information

GENERAL INFORMATION

Participant's Last Name:_____ First name: _____

Address:_____City:_____Zip:_____

Phones: Home:_____Cell:_____Work: _____

☐ **Text notifications for cancellations or important information**

E-mail Address:_____

Please include an email address that you check frequently. Email is a convenient and inexpensive way for us to contact you. We would like to use it to alert you of cancelations, session information and program events.

DOB:_____Age:_____Height:_____Weight:_____Gender: M F

School or Employer:_____Phone:_____

Teacher:_____Phone: _____

How did you come to know about our program? _____
Did you attend Freedom Hooves Therapeutic Riding Center in the past: Yes:_____No_____

Mother's/Guardian Information:

Name:_____Mailing Address: _____

City:_____State:_____Zip:_____Email:_____

Phone #s: Cell:_____Home: _____Work:_____

Place of Employment:_____Occupation:_____

Best way to get a hold of you (Please Circle one): Email Cell Phone Text Message Home Phone Work Phone

Father's Information:

Name:_____Mailing Address: _____

City:_____State:_____Zip:_____Email:_____

Phone #s: Cell:_____Home: _____Work:_____

Place of Employment:_____Occupation:_____

Best way to get a hold of you (Please Circle one): Email Cell Phone Text Message Home Phone Work Phone

Student Application and Health History – Page 2

Individual Responsible for Payment Information:

Name:_____ Mailing Address: _____

City:_____ State:_____ Zip:_____ Email:_____

Phone #s: Cell:_____ Home:_____ Relationship to Participant: _____

Caregiver name (if applicable):_____ Phone #: _____

Emergency Contact:_____ Relation:_____ Phone:_____

Emergency Contact:_____ Relation:_____ Phone:_____

Physician's Name:_____ Phone:_____

Preferred Medical Facility: _____

Health Insurance Company:_____ Policy #_____

Health History

Allergies:_____ Current Medications: _____

Significant Medical History:_____

Diagnosis:_____ Date of Onset: _____

Please indicate current or past needs in the following areas:

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Muscular			
Thinking/Cognition			
Bone/Joint			
Allergies			

Student Application and Health History – Page 3

Please answer each question to the best of your ability. We use *all* this information to develop lesson plans and goals for you or your rider. Please attach a separate sheet with more details if needed.

Medications

Name	Prescription	Over the Counter	Dose	Frequency

Other Current Therapies and Frequency:

_____

_____

_____

Physical Function

Describe abilities/difficulties in the following areas (include assistance required or equipment needed). For example: Mobility skills such as transfers, walking, wheelchair use, driving/bus riding

_____

_____

_____

Psycho/Social Function: (e.g. work/school- including grade completed, leisure interests, relationships, family structure, support systems, companion animals, fears, concerns, emotional struggles, etc.)

_____

_____

_____

_____

Goals: Why do you want to be a student at Freedom Hooves Therapeutic Riding Center? What would you like to accomplish? (Balance, independence, etc.)

_____

_____

_____

_____

PHOTO RELEASE

□ I DO □ I DO NOT

Consent to and authorize the use and reproduction by FREDOOM HOOVES THERAPEUTIC RIDING CENTER of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or any other use for the benefit of the program.

Signature: Student (if over 18): _____

Signature: Parent or Legal Guardian: _____

Date: _____

FREEDOM HOOVES THERAPEUTIC RIDING CENTER

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INFORMATION FOR PHYSICIAN

Dear Health Provider:

Your patient,_____, is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please check which of these conditions are present, and if so, to what degree:

ORTHOPEDIC

☐Atlantoaxial Instability (including neurologic symptoms)
☐Coxa Arthrosis
☐Heterotopic Ossification/ Myositis Ossificans
☐Joint Subluxation/ Dislocation
☐Osteoporosis
☐Pathologic Fractures
☐Spinal Joint Fusion/ Fixation
☐Spinal Joint Instability/ Abnormalities
☐ Cranial Deficits

NEUROLOGIC

☐Seizure Disorders
☐Spinal Bifida
☐Chiari II Malformation
☐Tethered Cord
☐Hydromyelia
☐Hydrocephalus/Shunt

☐ None of these conditions are present.

MEDICAL / PSYCHOLOGICAL

☐Allergies
☐Animal Abuse
☐Cardiac Conditions
☐Physical/Sexual/Emotional Abuse
☐Blood Pressure Control
☐Dangerous to self or others
☐Exacerbations of medical conditions (i.e. RA, MS)
☐Fire Settings
☐Hemophilia
☐Medical Instability
☐Migraines
☐PVD
☐Respiratory Compromise
☐Recent Surgeries
☐Substance Abuse
☐Thought Control Disorders
☐Weight Control Disorder

OTHER

☐Age – Under 4 years
☐Indwelling Catheters / Medical Equipment
☐Medication – i.e. photosensitivity
☐Poor Endurance
☐Skin Breakdown

Treating Physician Signature:_____Date:_____

Treating Physician Name (please print):_____Date:_____

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact me at (316) 733-8943.

Sincerely,
Amanda Hale - Executive Director

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SEIZURE DISORDER PARTICIPANTS – If Client does not have seizures write N/A

PATH (Professional Association of Therapeutic Horsemanship Association) recommends the following information for PATH Operating Centers for clients with seizure disorders:

Would you consider_____'s seizures to be: (please rate)
(name of participant)

□ Completely controlled □ Very well controlled □ Fairly controlled by medication

Type of Seizure:	
Typical Seizure:	
Typical motor activity during seizure:	
Description of client's behavior during post-ictal state:	Post-ictal state duration:
Specific directions as to what to do if a seizure should occur at Freedom Hooves Therapeutic Riding Center:	
Physician's Signature:	Date:

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PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant:_____ DOB:_____ Height:_____ Weight:_____
Address:_____
Diagnosis:_____ Date of Onset:_____
Past/Prospective Surgeries: _____
Medications:_____
Shunt Present: **Y N** Date of Last Revision _____
Special Precaution/Needs: _____

_____
Mobility: Independent Ambulation: **Y N** Assisted Ambulation: **Y N** Wheelchair: **Y N**
Braces/Assistive Devices: _____
For those with Down syndrome – AtlantoDens interval X-Rays: Date:_____ Result: **Pos Neg**
PATH recommends within the past 5 years and review every year; Physician Discretion for repeat x-ray.
Neurologic Symptoms of Atlanto Axial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the PATH center will weigh the medical information above against the existing precaution and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, PT, SLP, Psychologist, etc) in the implementation of an effective equine activity program.

Signature:_____ Date:_____
Name:_____ Date:_____
Address:_____ Title: **MD DO NO PA** Other _____
Phone: ( )_____ License/UPIN Number: _____

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NO CALL/NO SHOW POLICY

WHEN YOU ENROLL AT FREEDOM HOOVES THERAPEUTIC RIDING CENTER, we schedule you on a regular basis and a horse is prepared prior to each lesson. We also schedule staff and volunteers to meet the need of the class (both in individual and group).

Please call 24 hours in advance if you will **NOT** be able to attend your lesson. This helps us to adjust our program, volunteers and horses for the lessons if needed. If you cannot call 24 hours in advance, please make sure you call by 8:00 a.m. We will take into consideration emergencies, but **PLEASE CALL US**.

If you are more than 10 minutes late for your scheduled class you will **NOT** be able to ride. Please arrive on time. If you are consistently late we will need to discuss a different time that is more suitable.

All **No Call/NO Show absences will be charged the full lesson fee**. After three (3) No Call/No Shows you will be dropped from your class and will have to re-register. If you are on a full or partial scholarship, you will have to reapply.

Thank you for informing us of your unavailability for your scheduled lesson.
We appreciate your understanding and support.

By signing below I agree that I have read and understand FHTRC's No Call/ No Show policy.

Participant Name: _____

Parent/Participant Signature:_____Date: _____

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FREEDOM HOOVES
THERAPEUTIC RIDING
CENTER

FHTRC Therapeutic Riding Schedule

Please help us to serve you. If you could take a moment and answer the following questions based on your preferences, we would greatly appreciate it. We are considering how to best make use of FHTRC's time and schedule while we seek to meet your needs as well.

Answer the following:

1) Would you prefer morning or evening classes? _____

2) What weekday works best for you?
   ☐MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY

3) Please list in order the three times of day that would work best for your schedule

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FREEDOM HOOVES THERAPEUTIC RIDING CENTER
Billing Policies

FHTRC is committed to providing a quality therapy experience at an affordable rate. The majority of incurred expenses are financed through private donations, grants and fundraisers. While expenses have increased, we strive to keep our fees as low as possible.

We determine payment for therapeutic riding based on income. If this payment does not fit into your budget please indicate below that you are in need of a scholarship. FHTRC will do our best to provide a partial or full scholarship as need arises.

Fees:

****FHTRC does not bill Insurance or Medicaid****

Evaluations: Evaluations are performed by one of the FHTRC certified instructors for all new participants desiring to enter the program. Therapeutic Riding evaluation fees for new participants are $15.

Therapeutic Riding: We have a sliding scale fee based on your or family's income level. Proof of income level may be asked to submit prior to admittance into the therapy program. Please fill out the section below to determine your level. Full payment is required prior to the start of the riding session unless other arrangements have been made.

Scholarships: Scholarships are available if needed and if funding has been secured by FHTRC. Scholarships are based on your annual income and are available when funding permits. If you do not qualify for a scholarship, we also offer a discounted services program, which is based on how many hours you volunteer for FHTRC or how much you help raise in donations. If you need to request a scholarship or discounted services, please write a letter to the program explaining, in detail, your request including specific areas such as financial need, out of pocket expenses, therapeutic benefits, or other necessary information. All scholarship applications are reviewed at the end of each session by our scholarship committee. This committee is made up of members of the board of directors for Freedom Hooves.

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FREEDOM HOOVES
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PAYMENT AGREEMENT

Responsible Party for payment**:** _____

Family's Net Income: _____

Clients that can pay are asked to pay as much as they can. If you have any questions please call (316) 733-8943.

Client Name:_____DOB _____

Sliding Scale Fees

Please circle the best level for your income level and continue to the statements below.

$85,000 +	$55 per lesson
$64,500- $84,999	$45 per lesson
Less than $64,499	$35 per lesson

_____I agree to pay the amount listed on the sliding scale fee

_____ In order to participate in the FHTRC program, I am in need of a **partial** scholarship

_____In order to participate in the FHTRC program, I am in need of a **full** scholarship

By signing below I agree that I have read and understand FHTRC's billing policies.

Participant Name: _____

Parent/Participant Signature:_____Date: _____

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FREEDOM HOOVES THERAPEUTIC RIDING CENTER

Liability Release

As a volunteer/client/staff/student/board member at Freedom Hooves Therapeutic Riding Center I acknowledge the risks of a horseback riding program. However, I feel the possible benefits to myself and the participants I work with 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 Freedom Hooves Therapeutic Riding Center, its' Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I may sustain while participating in Freedom Hooves Therapeutic Riding Center program.

WARNING:
Under Kansas law, there is no liability for an injury to or the death of a participant in domestic animal activities resulting from the inherent risks of domestic animal activities, pursuant to K.S.A. 60-4001 through 60-4004. You are assuming the risk of participant in this domestic animal activity.

If client/volunteer is under 18 years of age, Parent/guardian must sign.

Name: (Please Print Clearly) _____

Signature:_____ Date: _____

Signature:_____ Date:_____
Parent/Guardian – if minor or legal guardian

D&J RANCH

RELEASE OF LIABILITY

KNOWING THAT RISK IS ALWAYS ATTACHED TO HORSEBACK RIDING AND IN CONSIDERATION OF THE SERVICES RECEIVED AND BEING DESIROUS OF RECEIVING INSTRUCTION ON THE RIDING OF HORSES BY _____(INSTRUCTOR). I_____(PARENT/GUARDIAN) OF _____

I DO HEREBY RELEASE AND DISCHARGE SAID INSTRUCTOR & THE D & J RANCH (DANE AND JENNIFER WADLEY) OF ANY AND ALL LIABILITY ARISING FROM THE RIDING AND/OR HANDLING OF HORSES UPON THE PREMISES KNOWN AS THE D & J RANCH, INCLUDING BUT NOT LIMITED TO LESSONS AND/OR DEFECTS IN RIDING EQUIPMENT (I.E. SADDLES, BRIDLES,ETC…).

I AGREE TO HOLD SAID INSTRUCTOR & THE D & J RANCH HARMLESS FROM ANY AND ALL CLAIMS AND LIABILITY THAT MAY BE MADE BY MYSELF OR ANYONE ON MY BEHALF INCLUDING COSTS AND REASONABLE ATTORNEY FEES.

THIS RELEASE IS BINDING UPON MY HEIRS AND ASSIGNS. _____

DATE___/__/____