Dear Prospective Participant,

Thanks for inquiring about The Hope Therapeutic Horsemanship Center. The possibilities are endless when it comes to the opportunities for mental and physical enhancement that can be gleaned from the back of a horse!

The Hope Therapeutic Horsemanship Center is a non-profit organization that seeks individual and corporate donations, government grants, living legacies and opportunities for fund raising events for a seven-week session. The approximate cost of running this program is $950 per horse per session. This amount covers board, feed, shoes, veterinary care, lease of the facility, games, office equipment, paid staff, insurance, license fees, PATH International dues, educational materials, printing and postage, and the tack needed to equip the horses for each individual rider.

Classes are 50 minutes in length, or as the participant allows, once a week. The participant learns basic horsemanship in the first 7-week session and progresses at his or her own pace in the following sessions. Please feel free to contact us if you have any questions at all. We’d love to hear from you!

Kelly Seiler, Program Director & Certified Riding Instructor

**The Hope Therapeutic Horsemanship Center**

**2019 E Harvest Circle**

**573-517-6004**

[www.hopecenterusa.org](http://www.hopecenterusa.org)

Email: kellyrae0715@gmail.com

**PARTICIPANT APPLICATION**

Last name: First Name:

Preferred Name:

Parent(s)/Guardian(s): Address:

Street: Apt# City: County:

State: Zip Code:

Phone:

Home:( )

Cell:( )

E-Mail:

Do you prefer text messages? yes no

Birth Date: Sex: M F

Height: Weight: (used in determining equipment and horse)

Please answer the following questions regarding the Participant:

1. Participant diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. When was the participant diagnosed? at birth

result of an accident date of accident

other date

1. Does the participant use any of the following?

wheelchair

walker

other (please explain)

cane crutches

braces

1. Has the participant ever been involved in therapeutic horseback riding before?

no yes if yes, how long?

1. Other extra-curricular types of therapy the participant uses or has used in the past:
2. Do you or your child have any particular goals you wish to achieve through this

program? Please explain:

**Information on this form may be used in the preparation of grant applications for program funding; however, names will be kept strictly confidential.**

# Participants Authorization for Emergency Medical Treatment Form

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while on the property of the agency, I authorize The Hope Therapeutic Horsemanship Center to:

* 1. secure and retain medical treatment and transportation if needed
  2. release client records upon request to authorized medical personnel

Participants name: phone:

Address: In the event I cannot be reached contact: phone:

or: phone: Physicians name: phone: Preferred Medical Facility: Health Insurance Co.: Policy #:

## Consent Plan

This authorization includes x-rays, surgery, hospitalization, medication, and any treatment procedure deemed “life saving” by the physician. The provision will only be invoked if the person below is unable to be reached. Date: Consent Signature:

Participant if 18 or older, parent or guardian

Print name: phone: Address:

## Non-Consent Plan

I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while on the property of the agency. In the event emergency aid/treatment is required, I wish the following procedures to take place:

Date: Non-consent signature:

Participant if 18 or older, parent or guardian Print name: phone: Address:

**This form is valid for a period of one (1) year from date signed.**

**A copy of the completed medical history should be attached to this form**.

## Riders Medical History and Physicians Statement

Name: DOB:

Address: zip: Parent/Guardian: Diagnosis: Date of onset:

\*\* For persons with Downs Syndrome:

negative cervical x-ray for Atlantoaxial Instability Date of x-ray:

negative for clinical symptoms of Atlantoaxial Instability

Tetanus shot: no yes Date: Hgt: Wt:

Seizure: Type

Controlled

Date of last seizure:

Medications:

**Please indicate of patient has a problem and/or surgeries in any of the following areas by checking……**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES or NO**  Auditory | **If YES, please comment:** | | |
| Visual |  | | |
| Speech |  | | |
| Cardiac |  | | |
| Circulatory |  | | |
| Pulmonary |  | | |
| Neurological |  | | |
| Muscular |  | | |
| Orthopedic |  | | |
| Allergies Learning  Disability |  | | |
| Mental  Impairment |  |  |  |
| Psychological  Impairment |  |  |  |
| Other |  |  |  |

Mobility: independent ambulation crutches braces wheelchair

special precautions

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

Physician name (please print) Physician signature Address City State Zip

Phone Date

**This form is valid for a period of one (1) year from the date signed.**

## Participant Release and Indemnification Agreement

I acknowledge and understand the inherent risks of horse activities and that horsemanship experiences can result in injury and even death. In consideration for being accepted into the The Hope Therapeutic Horsemanship Center and for the benefits I receive from participating in the program, I,

, (participant if 21 or older, parent or guardian) hereby consent to assume the risks of , (participant’s) participation in the horsemanship program sponsored by The Hope Therapeutic Horsemanship Center

Accordingly, I hereby, intending to be legally bound, for myself, my heirs and assigns, executors, or administrators, waive and forever release, acquit, discharge and hold harmless, The Hope Therapeutic Horsemanship Center, the owners of the facilities and properties on which The Hope Therapeutic Horsemanship Center conducts its therapeutic horseback riding program, including, but not limited to Rick and Claire Schemel, the officers, directors, agents, employees, representatives, therapists, instructors, and volunteers, of The Hope Therapeutic Horsemanship Center and any other person associated with The Hope Therapeutic Horsemanship Center therapeutic horseback riding program, and the successors and assigns of each of them, from all manner of claims, demands and damages of every kind and nature whatsoever I may now or in the future have against these parties on account of any losses or personal injuries, physical or mental condition, known or unknown to myself and the treatment thereof, as a result of, or in any way connected with the The Hope Therapeutic Horsemanship Center therapeutic horseback riding program, or growing out of acts of omission or caused by negligence or in any way incidental to the The Hope Therapeutic Horsemanship Center therapeutic horseback riding program.

## WARNING

**Under Missouri law, a Horse professional is not liable for any injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities pursuant to the Revised Statutes of Missouri.**

Date:

Signed:

Participant if 21 or older, parent or guardian

Witnesses:

# Photo Release

In consideration for being accepted into the The Hope Therapeutic Horsemanship Center therapeutic horseback riding program and for the valuable benefits I receive from participating in the program and promoting the program I, , hereby authorize The Hope Therapeutic Horsemanship Center, its advertising agencies, news media and or social media (including website) to have photographs, films or other audio-visual materials taken of the participant for promotional material, educational activities, exhibitions or for any other use for the benefit of the The Hope Therapeutic Horsemanship Center therapeutic horseback riding program. I hereby indemnify and hold The Hope Therapeutic Horsemanship Center harmless against any and all claims of damages arising out of the use of any such photographs or films of me or audio-visual materials containing the participants’ image.

Date:

Signed:

Participant if 21 or older, parent or guardian

Witnesses:

# I choose not to allow photographs, films or other audio-visual materials.

## WARNING

**Under Missouri law, a Horse professional is not liable for any injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities pursuant to the Revised Statutes of Missouri.**

**Equestrian Helmets**



**SEI Certified**

Meets or exceeds ASTM F1163-01 Standards

The Hope Therapeutic Horsemanship Center requires every student to purchase their own helmet. It must be SEI Certified equestrian riding helmet.

Helmets may be purchased at Buchheit’s Store in Perryville, MO as well as other tack stores in the Southeast area.