Welcome to Equine Dreams and thank you for your interest in Equine Assisted Activities!

- Please fill out the participant packet and send to the address listed below.
- If we have an opening, someone from Equine Dreams will contact you to schedule your orientation.
- We look forward to meeting you!

Send completed forms to:

Equine Dreams, P.O. Box 372, Sandwich, IL 60548
(please remember to add the correct postage for mailing)

Any Questions? Call (630) 553-6950 or E-mail us at: ride@equinedreams.org

Equine Dreams Participant's Application and Health History

(to be completed by parent or legal guardian)

GENERAL INFORMATION

Participant: _____ Date: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____ City/State/Zip: _____

Phone: _____ Email: _____ Alternate phone: _____

Please identify your race and ethnicity below: *(Information is used for grant reporting purposes.)*

- ☐ African American/Black
- ☐ Asian/Pacific Islander
- ☐ Caucasian/White, Non-Hispanic
- ☐ Hispanic/Latino
- ☐ Native American/American Indian
- ☐ 2 or more races
- ☐ Other - Please specify: _____

- ☐ please check if you are a Veteran

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

Phone: _____

How did you hear about our program? _____

_____

_____

_____

Initials of participant or guardian

HEALTH HISTORY

Diagnosis: _____ Age of Onset: _____

Please indicate current or past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

Equine Dreams Participant's Application and Health History

Medications (include prescription, over-the-counter; name, dose and frequency)

_____

_____

_____

_____

Describe your abilities/difficulties in the following areas *(include assistance required or equipment needed)*:
PHYSICAL FUNCTION (i.e. Mobility skills such as transfers, walking, wheelchair use, driving)

_____

_____

_____

_____

PSYCHO/SOCIAL FUNCTION (i.e. work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns,etc)

_____

_____

_____

_____

_____
Initials of participant or guardian

GOALS (i.e. why are you applying for participation? What would you like to accomplish?)

_____

_____

_____

_____

Signature: _____Date: _____

PHOTO RELEASE

I ☐ DO ☐ DO NOT

consent to and authorize the use and reproduction by Equine Dreams of any and all still and/or video photography and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Client, Parent or Legal Guardian

_____

Initials of participant or guardian

Equine Dreams Authorization for Emergency Medical Treatment Form/ Liability Release

☐Participant ☐Staff ☐Volunteer

Name: _____DOB: _____ Phone: _____

Address: _____City/State/Zip: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy#: _____

Allergies to medications: _____ Current medications: _____

In the event of an emergency, contact:
Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Consent Plan

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize **Equine Dreams** 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-rays, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: _____ Consent Signature: _____
Client, Parent or Legal Guardian

Non-Consent Plan

I **do not** give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of Equine Dreams.

☐ Parent or guardian will remain on site at all times during equine assisted activities.

Date: _____ Non-Consent Signature: _____
Client, Parent or Legal Guardian

Liability Release

_____ would like to participate in the Equine Dreams activities program. I acknowledge the risks and potential risks of horseback riding and of driving horses or ponies. **Under the Equine Activity Liability Act, each participant who engages in an equine activity expressly assumes the risks of engaging in and legal responsibility for injury, loss, or damage to person or property resulting from the risks of equine activities. Under Illinois law, an equine activity sponsor or professional shall not be liable for any injury to, or the death of a participant in equine activities resulting from the inherent risk of equine activities. I acknowledge the risks and potential for risks of horseback riding and related equine activities involving equines and/or farm animals.** However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs, and assigned executors or administrators, waive and release forever all claims and damages against Equine Dreams, equine activities, it's board of directors, instructors, therapists, aides, volunteers, boarding facilities, boarders, and/or property owners, and/or employees for any and all injuries which I/my son/my daughter/my ward may sustain while participating in the Equine Dreams activities program.

Date: _____ Consent Signature: _____
Client, Parent or Legal Guardian

_____
Initials of participant or guardian

Equine Dreams, Inc. Therapeutic Riding Center

Release and Hold Harmless Agreement

WHEREAS, the UNDERSIGNED acknowledges the inherent risks involved in riding and working around horses, these risks include bodily injury from using, riding or being in close proximity to horses, among other risks, and further, that both horses and rider can be injured in normal use or in competition and schooling.

IN CONSIDERATION, therefore, for the privilege of riding and/or working around horses at Equine Dreams, Inc., located at 9775 Fox River Drive, Newark, IL 60541, the undersigned does hereby agree to hold harmless and indemnify Equine Dreams Inc. and further release them from any liability or responsibility for accident, damage, injury, or illness to the Undersigned or any horse owned by the Undersigned or to any family member or spectator accompanying the Undersigned while on the premises of Equine Dreams Inc. and that except in the event of this stables gross and willful negligence, I shall bring no claims, demands, actions and causes of action, and/or litigation, against this stable for any economic and non-economic losses due to bodily injury, death, and/or property damage sustained by me and/or my minor child or legal ward in relation to the premises and operations of this stable, including while riding, hauling, lessons, adopting horses, shows, activities, trailering, etc.

Date: _____

Signature: _____

Signature of Parent or Guardian: _____

Print Name: _____

Address: _____

Witness Signature: _____

Witness Print Name: _____

P.O. Box 372, Sandwich, IL 60548
www.equinedreams.org

_____
Initials of participant or guardian

(please send the next 2 forms to the participant's physician to be completed**)**

Date: _____

Dear Healthcare Provider:

Your patient, _____, is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete the attached Medical History/Physician's Statement Form. 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 to what degree.

Orthopedic
Atlantoaxial Instability-include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/Dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instabilities/ Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Cord/HydroMyelia

Other
Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. Photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of Medical Conditions (ie. M.S., RA)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

Thank you so 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 our center through email at ride@equinedreams.org.

Sincerely,

Equine Dreams Therapeutic Riding Center

_____
Initials of participant or guardian

Equine Dreams Participant's Medical History & Physician's Statement(to be completed by physician)

Participant: _____DOB: _____ Height: _____ Weight: _____

Address: _____ City/State/Zip: _____

Diagnosis: _____ Date of Onset: _____

NOTE: Because of the nature of the activity of horseback riding, no individual diagnosed with Down syndrome can be accepted for riding instruction without an annual medical clearance, signed and dated from a licensed physician that includes a neurologic exam that specifically denies any symptoms consistent with Atlantoaxial Instability (AAI)

For those with Downs Syndrome: AtlantoDens Interval X-rays, date: _____ Result + --
Neurologic Symptoms of Atlantoaxial Instability: Present Absent

Past/Prospective Surgeries: _____

Medications: _____ Braces/Assistive Devices:_____

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

Shunt present: Y N Date of last revision: _____

Special Precautions/Needs: _____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

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

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that Equine Dreams will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Equine Dreams for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____

_____
Initials of participant or guardian

Equine Dreams Participant's Consent for Release of Information

I hereby authorize: _____
(Person or facility)

to release information from the records of: _____ DOB: _____
(Participant's name)

The information is to be released to: **Equine Dreams**
for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

- ☐ Medical History
- ☐ Physical Therapy evaluation, assessment and program plan
- ☐ Occupational Therapy evaluation, assessment and program plan
- ☐ Mental Health diagnosis and treatment plan
- ☐ Individual Habilitation Plan (I.H.P.)
- ☐ Classroom Individual Education Plan (I.E.P.)
- ☐ Psychosocial evaluation, assessment and program plan
- ☐ Cognitive-Behavioral Management Plan
- ☐ Other: _____

This release is valid for one year and can be revoked, in writing, at my request.

Signature: _____ Date: _____

Print Name: _____

Relation to Participant: _____

Please send materials to: _____

_____

_____

_____

_____
Initials of participant or guardian

Equine Dreams Therapeutic Riding Center Rules
Welcome Volunteers, Parents and Students!

We'd like to remind you of our barn rules:

- Parents, family members, and guests, **please remember to stay in the parent viewing area, behind the white fence, unless specifically asked or invited by staff to come to the arena area.**
- **Please refrain from engaging in conversation with your child or any riders during their lesson time. This can be extremely distracting to students, staff and volunteers who may need to listen for important lesson and safety instructions.**
- No smoking.
- Everyone must wear a helmet when riding.
- No running or yelling.
- No dogs allowed (except assistance dogs).
- All riders are required to use safety Peacock stirrups or Western Sidestep Break- away stirrups.
- Everyone is required to wear fully enclosed shoes.
- Children must be under adult supervision at all times.
- All horse areas are off limits.
- Do not feed the horses by hand.
- All horse paddocks, stalls and fields are off-limits.
- No one is allowed on this property without the presence/supervision of an Equine Dreams registered riding instructor and/or a designated staff member.
- No activities are to be performed on this property after dark.
- No equine assisted activity on this property without the supervision of a PATH Intl. registered riding instructor.

_____
Initials of participant or guardian

Equine Dreams Participant's Profile

(next three pages to be completed by instructor)

Name: _____ Date: _____

Disability: _____

Ambulatory Status: _____Allergies: _____

Adapted Equipment Required: _____

Mounting/Dismounting (method, number of volunteers) _____

_____

Helpers required (indicate gait* assistance needed; update as needed):

Type of Assistance	**Date**	**Gaits**	**Date**	**Gaits**	**Date**	**Gaits**
Leader and 2 side walkers						
Leader and 1 side walkers						
Leader only						
Side walker						
Independent						

Riding Position (describe): _____

_____

_____

Riding skills (indicate gait*/task is completed; update as needed):

Task	**Date**	**Gaits**	**Date**	**Gaits**	**Date**	**Gaits**
Hold reins						
Hold handhold						
Able to control horse						
Able to circle at the…						
Rides w/out stirrups						
Able to maintain half seat						
Able to post at the…						
Knows diagonal or lead						
Able to steer over cavalletti						

Rider can walk _____ sitting trot _____posting trot _____ canter _____

Horse recommendations _____

_____

*Gaits Key: W – walk; ST – sitting trot; PT – posting trot; C - canter

_____

Initials of participant or guardian

PROGRESS NOTES

Date: _____
Instructor: _____

Name _____ Start Date: _____ DOB: _____

Volunteers:_____

Goals:_____

_____

Horse/Mounts/Precautions: _____

_____

If in group lesson, list group members _____

Group Goals: _____

_____

Week #1 Lesson Summary: _____

_____

Week #2 Lesson Summary: _____

_____

Week #3 Lesson Summary:

_____

_____

Week #4 Lesson Summary: _____

_____

Summary:

_____

_____

_____

_____

_____
Initials of participant or guardian

Equine Dreams
LESSON PLAN

Instructor:_____
Riders Name: _____ **Season:_____**

Objective(s) of Lesson:

Teacher Preparation/Equipment Needed:

Lesson Content/Procedure:

Summary and Evaluation:

_____
Initials of participant or guardian