Liberty Riders, Inc.

7103 GRATIOT RD. / ST. CLAIR / MI/ 48079
PH. 810-367-6471
EMAIL. libertyridersorg@comcast.net
Website: www.libertyriders.org

Hello and welcome to Liberty Riders, Inc. Lesson Schedule for 2011!

Session 1	March 21 – April 25, 2011 *REGISTRATION DUE: MARCH 1*	Session 1 Will Be Only 5 Weeks! **NO LESSONS** the week of **April 4.**
Session 2	May 2 – June 6, 2011 *REGISTRATION DUE: APRIL 18*	
Session 3	June 13 – July 18, 2011 *REGISTRATION DUE: MAY 30*	
Session 4	August 8 – September 19, 2011 *REGISTRATION DUE: JULY 18*	
Session 5	October 17 – November 21, 2011 *REGISTRATION DUE: SEPTEMBER 19*	

- Riding sessions will be 6 weeks long
- We MUST receive all forms by date indicated OR the rider will not be allowed to participate in the session.
- Lesson slots will be filled based upon the rider's suitability for a particular class. We will group lessons according to age, riding skills, and availability of horses.
- The fee for Sessions for **2011** will be:

  Lessons are **$120.00** for 6 weeks (Session 1 will be $100.00)

  - Must be paid in full at the first lesson
  - Non- Refundable

KEEP FOR YOUR RECORDS

Explanation of Lessons

LESSON REQUIREMENTS:

1. Minimum age is 4 years old- evaluated by an instructor
2. Weight limit of rider not to exceed **200lbs**
3. Rider is responsible for proper riding attire.
   - Hard soled boots with a drop down heel recommended. (Other footwear needs to be approved by instructor.)
   - Long pants – preferably jeans. **NO Shorts or Capri pants**
   - Layer clothing so you can adjust to weather conditions.
   - NO spaghetti strap tank tops or mid drifts.
4. Must wear an ASTM-SEI approved helmet at all times while mounted. Liberty Riders, Inc. has helmets available during lessons, but we recommend you to purchase your own helmet.
5. Lessons are approximately one hour –evaluated by the instructor.
6. Maximum class size is 6 riders
7. Lessons are offered Monday through Thursday

PLEASE ARRIVE 10 MINUTES BEFORE LESSON TIME. IF A RIDER IS GOING TO BE LATE FOR A GROUP LESSON, THEY WILL NOT BE ABLE TO RIDE. HOWEVER, OBSERVING A LESSON CAN BE VERY BENEFICIAL TO A RIDER, AND IS RECOMMENDED. THE RIDER MAY ALSO BE ABLE TO ASSIST THE INSTRUCTOR WITH THE LESSON. WE WILL **NOT** HOLD LESSONS FOR LATE RIDERS.

IF LIBERTY RIDERS, INC. NEEDS TO CANCEL A LESSON, THE LESSON WILL BE RESCHEDULED ACCORDING TO THE AVAILABILITY OF INSTRUCTOR.

IF YOU NEED TO CANCEL YOUR LESSON PLEASE INFORM LIBERTY RIDERS, INC. AS SOON AS POSSIBLE. HOWEVER, THESE LESSONS **WILL NOT BE RESCHEDULED**.

If you have any questions about any forms or information, please feel free to call us at 810-367-6471 or Email us at ***libertyridersorg@comcast.net***

Sue E. Cook
President

Sarah A. Cook
Instructor

KEEP FOR YOUR RECORDS

LIBERTY RIDERS INC. RIDER'S APPLICATION

SESSION # _____ PLEASE INDICATE WHICH SESSION YOU ARE APPLY FOR

RIDER'S NAME: _____ Age: _____

ADDRESS: _____ CITY: _____ ZIP: _____

PHONE (S): HOME- _____ WORK- _____ CELL- _____

Email Address: _____

PRIMARY DISABILITY: _____ SECONDARY DISABILITY: _____

BIRTH DATE: _____ GENDER: _____ HEIGHT: _____in. WEIGHT: _____lbs.

(200lb weight limit)

****If rider is less than 18 years of age, the parent or legal guardian must fill in below:**

FATHER: _____ PHONE # (home) _____

EMPLOYER: _____ (work) _____

MOTHER: _____ PHONE # (home) _____

EMPLOYER: _____ (work) _____

GUARDIAN: _____ Phone # (home) _____

EMPLOYER: _____ (work) _____

[ ] Mother [ ] Father [ ] Guardian– address, if different from above:

_____

(Street) (City) (State) (Zip)

IN CASE OF EMERGENCY CONTACT: _____ PHONE: _____

CONTACT: _____ PHONE: _____

RIDER PROFILE:

Please check all that apply:

____ Have never ridden before

____ Have ridden a few times but no formal lessons: Describe: _____

____ Have taken lessons: Location: _____ # of Years: _____
Style of riding: _____

____ Have taken lessons with Liberty Riders Inc. before: When: _____ # of Years: _____

CLASS SCHEDULES AND REGISTRATION

RIDER LEVELS:

RIDERS WILL BE EVALUATED BY AN INSTRUCTOR TO CONFIRM ABILITIES AND THE LEVEL AT WHICH THEY WILL BE RIDING.

RIDING LESSON CLASS SCHEDULE:

PLEASE MARK YOUR CHOICE OF RIDING TIMES IN ORDER OF PREFERENCE BY WRITING 1ST, 2ND, 3RD, IN THE SPACE TO THE RIGHT OF THE TIME. PLEASE REMEMBER THERE ARE NO GUARANTEES THAT YOUR CHOICES WILL BE AVAILABLE, HOWEVER, WE WILL DO OUR BEST TO ACCOMMONDATE YOUR PREFERENCES. AN INSTRUCTOR WILL CONTACT YOU TO SET UP A SCHEDULE ACCORDING TO THE TIME SLOTS AVAILABLE.

Please indicate which session you are applying for _____

Monday	Tuesday	Wednesday	Thursday	
AM	AM	AM	AM	
Afternoon	Afternoon	Afternoon	Afternoon	
PM	PM	PM	PM	

NOTE:

- **Time includes grooming and tacking/ un-tacking horses**
- **Class size is maximum of 6 riders**
- **Style of riding determined by instructor and level of rider**
- **Lessons are determined by age and ability of rider**

Please answer the following questions?

1. What are your short-term goals, specifically for this session?

   _____

   _____

2. What are your long-term goals?

   _____

   _____

Please make checks payable to **Liberty Riders Inc**.

Return completed forms to:

Liberty Riders Inc.
7103 Gratiot
St Clair, MI 48079
Telephone. 810-367-6471

Email. LibertyRidersOrg@comcast.net
Website. www.LibertyRiders.org

Lesson Fee
6 Weeks - $120.00
5 Weeks - $100.00

Lesson Fees Must Be Paid in Full
at the First Lesson
PLEASE DO NOT PAY IN ADVANCE
Paying in advance does not guarantee you a slot in a session

Rider's Registration and Release Form

Name: _____Date of Birth: _____ Age: ____

Street: _____ City: _____State: _____Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

School or Institution presently attending: _____

In case of emergency Contact: _____ Phone: _____

Contact: _____ Phone: _____

****

PHOTOGRAPHY, VIDEO AND WEB PUBLISHING

Riders may be photographed or videotaped and their names published for non-profit use in various ways: newsletter articles, community newspaper articles, videos, television broadcasts, lesson pictures, and Liberty Riders web pages. If you do not want your child to have his/her name, picture or video taken please make your request in writing.

****

LIABILITY RELEASE

MUST BE FILLED OUT IN ORDER TO RIDE!!!

_____ (*Rider's Name*) would like to participate in the ***Liberty Riders Inc.*** therapeutic riding program. I acknowledge the risks and potential for risks of horseback riding. 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 assigns, executors or administrators, waive and release forever all claims for damages against ***Liberty Riders Inc.,*** its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/ my son/ my daughter/ my ward may sustain while participating in ***Liberty Riders Inc.***

WARNING: *Under the Michigan Equine Activity Liability Act, an equine professional is not liable for an injury to or death of a participant in an equine activity resulting from an inherent risk of the equine activity.*

Date: _____ Signature: _____

Client, Parent or Guardian

Emergency Medical Treatment Release Form

RIDER NAME:

_____

PARENT/ LEGAL GUARDIAN:

_____

ADDRESS:

_____
(STREET) (CITY) (STATE) (ZIP)

PHONES: HOME: _____ WORK: _____ CELL: _____

RIDER DIAGNOSIS: _____ DATE OF ONSET: _____

DATE OF BIRTH: _____ GENDER: _____ AGE: _____

INSURANCE CARRIER_____ POLICY NUMBER_____

Medical Facility Preferred**:**

_____

PHYSICIAN'S NAME: _____ PHONE: _____

OFFICE ADDRESS:

_____
(STREET) (CITY) (STATE) (ZIP)

EMERGENCY CONTACT (OTHER THAN PARENT/GUARDIAN)

NAME:

_____

PHONES: _____ RELATIONSHIP: _____

Describe any medical conditions requiring special treatment, including allergies, and any current medications and dosage:

_____

_____

Emergency Medical Treatment Release Form Continued

In case of medical emergency, the undersigned authorizes ***Liberty Riders Inc.*** to provide such medical assistance as they determine to be necessary. If the rider named above is younger than 18 years, the undersigned authorizes ***Liberty Riders Inc.*** acting through the adult on its staff who has actual care, control, and possession of the child to consent to medical, dental, and surgical treatment of the child when the undersigned cannot be contacted. The undersigned represents to ***Liberty Riders Inc.*** that he or she is the child's parent and either (i) is not divorced from the other parent, or (ii) is divorced from the other parent, but has been authorized by a written court order to give consent to medical and dental care and surgical treatment of the child. The undersigned will indemnify and hold ***Liberty Riders Inc.*** it's officers, members, employees, and agents harmless if he or she is not empowered by law to give this consent.

The undersigned authorizes any licensed physician and/or medical facility to provide any medical/surgical care and/or hospitalization for the child, 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 this form has been completed by the parent/parents or guardian. 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 organization concerned with this instruction, including ***Liberty Riders Inc.*** in the event of any accident that may occur.

WARNING: *Under the Michigan Equine Activity Liability Act, an equine professional is not liable for an injury to or death of a participant in an equine activity resulting from an inherent risk of the equine activity.*

CONSENT SIGNATURE: _____ DATE: _____
(PARTICIPANT IF LEGALLY ABLE OR PARENT/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 the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

NON- CONSENT SIGNATURE: _____ DATE: _____
(PARTICIPANT IF LEGALLY ABLE OR PARENT/GUARDIAN)

PHYSICIAN'S STATEMENT AND MEDICAL HISTORY

*All application records must be updated annually

RIDER'S NAME: _____ DATE: _____

ADDRESS:

_____
(STREET) (CITY) (STATE) (ZIP)

BIRTH DATE: _____ AGE: _____

NAME OF [ ] PARENT OR [ ] GUARDIAN:

_____

PRIMARY DIAGNOSIS: _____ ICD CODE: _____

ONSET (PLEASE CHECK ONE): [ ] BIRTH [ ] CHILDHOOD
[ ] ADOLESCENCE [ ] ADULTHOOD

SECONDARY DIAGNOSIS: _____ TERTIARY: _____

HEIGHT: _____ INCHES WEIGHT: _____ LBS.

TETANUS SHOT: [ ] YES [ ] NO DATE OF MOST RECENT: _____

PLEASE LIST ALL CURRENT MEDICATIONS

1. _____ TAKEN FOR _____
2. _____ TAKEN FOR _____
3. _____ TAKEN FOR _____

TYPE OF SEIZURE: _____ CONTROLLED? _____
DATE OF LAST SEIZURE: _____

MOBILITY: AMBULATORY: ___ YES ___ NO; WHEELCHAIR: ___ YES ___ NO;
CRUTCHES: ___ YES ___ NO; BRACES: ___ YES ___NO

PLEASE DESCRIBE ANY SPECIAL PRECAUTIONS NEEDED:

_____
_____

_____ _____
SIGNATURE OF PARENT OR GUARDIAN (REQUIRED) DATE

OR

_____ _____
SIGNATURE OF ADULT RIDER (AGE 18 OR OLDER) (REQUIRED) DATE

PHYSICIAN'S STATEMENTAND MEDICAL HISTORY CONTINUED

(PLEASE REVIEW AND COMPLETE THE INFORMATION ON NEXT PAGE)

When completed with all signatures, please return both forms to:

Liberty Rider's Inc. 7103 Gratiot Road, St Clair MI 48079
Tel: 810-367-6471
Email. LibertyRidersOrg@comcast.net
Website. www.libertyridersinc.org

This information must be completed by the physician

RIDER'S NAME: _____

Physician, please note—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. Please be as specific as possible so that we may best serve the rider's needs.

Orthopedic
Spinal Fusion
Spinal Instabilities/ Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Ontogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Injury
Internal spinal stabilization devices

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
Age Under 2 years
Age 2-4 years
Acute exacerbation of chronic disorder
Indwelling Catheter

Neurologic
Hydrocephalus/ Shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis due to Spinal Cord

Seizure Disorders

RIDERS WITH DOWN SYNDROME – PLEASE NOTE:

Due to the nature of the activity of horseback riding, no individual diagnosis with Down syndrome can be accepted for riding instruction without proof of a negative diagnosis x-ray for Atlantoaxial Instability. Please provide the following information:

a) Most recent cervical x-ray for AAI: [ ] Positive [ ] Negative …Date of x-ray _____

b) Annual cervical exam for AAI: [ ] Positive [ ] Negative… Date of Exam._____

PLEASE BE SURE TO FILL THIS OUT COMPLETELY FOR ALL RIDERS! IT'S VERY IMPORTANT!

DOES THE RIDER HAVE A PROBLEM WITH, AND/OR SURGERIES IN, ANY OF THE FOLLOWING AREAS? IF YES, PLEASE EXPLAIN:

AREA	YES	NO	EXPLANATION (Please provide details)
AUDITORY			
VISUAL			
VISION WITHOUT CORRECTION: VISION CORRECTED TO:			
SPEECH			
CARDIAC			
CIRCULATORY			
PULMONARY			
NEUROLOGICAL			
MUSCULAR			
ORTHOPEDIC			
ALLERGIES			
LEARNING DISABILITY			
MENTAL IMPAIRMENT			
PSYCHOLOGICAL IMPAIRMENT			
OTHER:			

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 I have provided on the next page against the existing precautions and contraindications.

Physician Name (please print):_____

Physician Signature (REQUIRED): _____DATE_____

Office Address:

_____

(Street) (City) (State) (Zip)

Office Phone: _____