Liberty Riders, Inc.

Special Needs Equestrian Program

2019 NEW RIDER LESSON PACKET

Thank you for your interest in therapeutic horseback riding. Liberty Riders, Inc. is a therapeutic riding program designed to benefit the riders physically, socially, and emotionally. Safety equipment and specially trained horses and volunteers are used. In order to assure the fullest possible protection and greater personal benefit from the program, each rider is required to furnish the following rider information before accepted in the program.

In order to begin riding at Liberty Riders, Inc., complete the following:

- ✓ ***Completely fill out*** the student packet to considered for a mandatory evaluation (NOTE: the Physician Referral must be signed by your doctor)
- ✓ Any questions or concerns please contact Liberty Riders, Inc. by:
  - Email: libertyridersinc@gmail.com
- ✓ Mail or bring completed forms to:

  Liberty Riders, Inc.
  7103 Gratiot Rd.
  St. Clair, MI 48079

- ✓ After receiving completed forms, Liberty Riders, Inc. will contact you for a MANDATORY EVALUATION prior to scheduling.
- ✓ **PLEASE NOTE LESSON FEES FOR 2019 ARE**:
  - **5 – weeks = $150**
  - **6 – weeks = $180**
- ✓ Payment will not be accepted until first scheduled lesson. Paying ahead does **NOT** guarantee the rider a lesson slot.

LIBERTY RIDERS INC.

RIDER REGISTRATION & RELEASE FORMS

RIDER'S NAME: ____AGE: __________

ADDRESS: ___________________________ CITY: ___________________ ZIP: __________

PHONE(S): HOME: ____________________________ CELL: __________________________

EMAIL ADDRESS: ____

BIRTH DATE: _______________ GENDER: ________ HEIGHT: _______IN. **WEIGHT**: __________LBS.

**** ***200-pound weight limit*** *variable dependent upon ambulatory status, ROM, and discretion of instructor*****

****IF RIDER IS LESS THAN 18 YEARS OF AGE, THE PARENT OR LEGAL GUARDIAN MUST FILL IN BELOW:**

FATHER: _________________________________ PHONE(S): HOME: ________________

EMPLOYER: ______________________________ PHONE(S): WORK: ________________

MOTHER: ________________________________ PHONE(S): HOME: ________________

EMPLOYER: ______________________________ PHONE(S): WORK: ________________

GUARDIAN: ______________________________ PHONE(S): HOME: ________________

EMPLOYER: ______________________________ PHONE(S): WORK: ________________

IF ADDRESS IS DIFFERENT THE ABOVE: ☐ **MOTHER** ☐ **FATHER** ☐ **GUARDIAN**

____

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

IN CASE OF EMERGENCY CONTACT: _____________________________ PHONE: ______________

CONTACT: _____________________________ PHONE: ______________

HEALTH HISTORY AND PHYSICIAN REFERRAL FORMS

PRIMARY DISABILITY: ____________________________ SECONDARY DISABILITY: ________________

DATE OF ONSET: (PLEASE CHECK ONE): ☐ BIRTH ☐ CHILDHOOD ☐ ADOLESCENCE ☐ ADULTHOOD

LIST ALL CURRENT MEDICATIONS:

1. ________________________________ TAKEN FOR: ______________________
2. ________________________________ TAKEN FOR: ______________________
3. ________________________________ TAKEN FOR: ______________________

MOBILITY: AMBULATORY: ☐ YES ☐ NO WHEELCHAIR: ☐ YES ☐ NO

CRUTCHES: ☐ YES ☐ NO BRACES: ☐ YES ☐ NO

HEALTH HISTORY AND PHYSICIANS REFERRAL FORMS CONTINUED:

DOES THE RIDER...	YES	NO	COMMENTS
HAVE A HISTORY OF SEIZURES?			
FOLLOW SIMPLE DIRECTIONS?			
HAVE SPEECH OR LANGUAGE DIFFICULTIES?			
HAVE COMMUNICATION DIFFICULTIES?			
HAVE A FEAR OF ANIMALS/ HORSES/ DOGS?			
WALK INDEPENDENTLY?			
HAVE LIMITED RANGE OF MOTION?			
HAVE DECREASED STRENGTH/ ENDURANCE?			
HAVE POOR BALANCE: SITTING/ STANDING?			
HAVE PROBLEMS WITH GROSS MOTOR SKILLS?			
HAVE PROBLEMS WITH FINE MOTOR SKILLS?			
HAVE ALTERED SENSATION? (SPECIFY)			
HAVE HEART/ CIRCULATORY PROBLEMS?			
HAVE DIGESTION/ ELIMINATION PROBLEMS?			
HAVE BONE/ JOINT PROBLEMS?			
HAVE ALLERGIES/ BREATHING PROBLEMS?			
HAVE EMOTIONAL/ BEHAVIORAL PROBLEMS?			

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/ DISLOCATION CONDITION.

IF DIAGNOSIS IS DOWN SYNDROME, THIS FORM MUST BE ACCOMPANIED BY ONE OF THE FOLLOWING:

- MICHIGAN SPECIAL OLYMPIC DOWN SYNDROME ATHLETE EVALUATION
- A SIGNED, DATED STATEMENT FROM A QUALIFIED PHYSICIAN GIVING THE DATE AND RESULTS OF THE DIAGNOSTIC X-RAY FOR ATLANTOAXIAL INSTABILITY/ DISLOCATION CONDITION

Liberty Riders, Inc. is a therapeutic riding program designed to benefit the riders physically, socially, and emotionally. Safety equipment and specially trained horses and volunteers are used. In order to assure the fullest possibly protection and greater personal benefit from the program, each rider is required to furnish the following medical information before accepted in the program.

PHYSICIAN MUST COMPLETELY FILL OUT THIS BOX!

IN MY OPINION THE PATIENT NAMED ABOVE CAN RECEIVE RIDING INSTRUCTION UNDER APPROPRIATE SUPERVISION.

Physician Signature: ____ Date: ____________________

Physician's Printed Name: ____

Address: _____________________________________ City: _________________________ Zip: ___________

Phone: ____ Fax: ___________________________________

CONSENT FOR EMERGENCY MEDICAL TREATMENT

RIDER'S NAME: ____

DATE OF BIRTH: ______________________________________ AGE: _______ GENDER: _____________

PHYSICIAN'S NAME: ____

PERSON AUTHORIZED TO GIVE TEMPORARY ASSISTANCE OF CARE IN THE ABSENCE OF PARENT/GUARDIAN:

NAME: ____

PHONE(S): ______________________________________ RELATIONSHIP: _________________________

PREFERRED MEDICAL FACILITY: ____

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.

____ DATE: _______________________

SIGNATURE OF PARENT/ GUARDIAN (UNDER THE AGE OF 18 YRS.)

____ DATE: _______________________

SIGNATURE OF ADULT RIDER (OLDER THAN 18 YRS.)

____ ____

INSURANCE CARRIER POLICY NUMBER

RIDING LESSON SCHEDULING INFORMATION

RIDING LESSON AVAILABILITY: LIST THE DAY ***(MONDAY – THURSDAY)*** AND THE TIME YOU COULD ARRIVE FOR WEEKLY LESSONS.

1ST CHOICE: ______ ______ 2ND CHOICE: _______ _______ 3RD CHOICE: _______ _______

DAY TIME DAY TIME DAY TIME

CHECK THE SESSIONS YOU ARE INTERESTED IN BELOW:

********(FORMS DUE TWO WEEKS BEFORE SESSION STARTS)********

- ☐ **1 – APRIL 8 – MAY 13 (6 WEEKS $180)**
- ☐ **2 – MAY 20 – JULY 1 (6 WEEKS $180)**
- ☐ **3 – JULY 29 – AUGUST 26 (5 WEEKS $150)**
- ☐ **4 – SEPTEMBER 9 – OCTOBER 14 (6 WEEKS $180)**
- ☐ **5 – OCTOBER 21 – NOVEMBER 25 (6 WEEKS $180)**

HAVE YOU EVER TAKEN RIDING LESSONS BEFORE? ______ IF YES, EXPLAIN: ____

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PHOTOGRAPHY, VIDEO AND WEB PUBLISHING

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

LIABILITY RELEASE

___________________________________(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 me/ my son/ my daughter/ my ward are greater than the risks 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.* riding program.

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

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BY SIGNING BELOW, YOU ARE ACKNOWLEDGING, ACCEPTING, AND AGREEING TO ALL OF THE ABOVE RELEASES, LIABILITIES, AND CONDTIONS.

____ Date: __________________________

Print Name of Parent or Legal Guardian (If Under 18 Yrs.)

____ Date: ___________________________

Signature of Parent or Legal Guardian (if Under 18 Yrs.)