



CHEFF THERAPEUTIC RIDING CENTER

Welcome New Student!

Thank you for your interest in therapeutic horseback riding. Our staff, volunteers and horses are all excited about giving you the opportunity to experience the wonderful world of horses!

In order to begin riding at Cheff, complete the following:

- ❖ Fill out the student packet included with this cover sheet (note: the Physician Referral must be signed by your doctor)
- ❖ Call Tamara Homnick, Program Director at 269-731-4471, x 121 or email her at Tam@cheffcenter.org to sign up for an assessment and/or to answer any questions you may have.
- ❖ Mail or bring completed paperwork with you when you arrive for the first time.

We're looking forward to having you join us soon ☺



Cheff Therapeutic Riding Center

Participant Application & Health History

GENERAL INFORMATION

Participant name _____ Date _____

Address _____

City _____ State _____ Zip _____

County _____ DOB _____ Age _____

Gender: M F Height _____ Weight _____*

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

Home ph: _____ Alternate ph: (specify) _____

Parent/Legal guardian _____

Address (if different from above) _____

Email address _____

How did you hear about our program? _____

HEALTH HISTORY (attach additional sheet if necessary)

Diagnosis/Disability _____

Other therapies currently received _____

Current medications _____

Psycho-social function (interests, family structure, support system, etc) _____

Please mark any of the following that have been a recent or past issue, and provide specific comments where applicable. These items will not be used to prevent anyone from participating; rather, they are to assist us in best meeting your needs:

- Mental health therapy _____
- Legal problems _____
- Grief/Loss _____
- Trauma _____
- Special assistance at school _____
- Substance abuse _____
- Family problems _____

Special assistance required (Cheff Center cannot provide these, but it helps us to plan classes/lessons)

- Sign interpretation _____
- Service dog assistance _____
- Wheelchair assist/transfer _____
- Visual assistance/aids _____
- Emotional/mental helper _____

Has the student had prior experience with therapeutic riding? YES NO

If so, when and where? _____

Participant Name: _____

Does the student...	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?			
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/circulation problems?			
Have digestion/elimination problems?			
Have bone/joint problems?			
Have allergies or breathing problems?			
Have emotional/behavioral problems?			

GOALS

What would you like to accomplish in our program? _____

ADDITIONAL COMMENTS

Please provide any additional information that you feel would be helpful in class selection and lesson planning for this participant _____

Please call the Cheff Therapeutic Riding Center at 269-731-4471 with any questions.

Participant signature

Date

Parent/Guardian signature

Date

Mail completed forms to: **Tamara Homnick, Program Director**
Cheff Therapeutic Riding Center
8450 North 43rd Street
Augusta MI 49012



Cheff Therapeutic Riding Center

8450 North 43rd Street, Augusta MI 49012
Tel: 269.731.4471 Fax: 269.731.2990

Photo & Emergency Treatment Release

Participant: _____ Date of birth: _____
Disability & date of onset: _____
Parent/Guardian: _____
Address _____
City _____ State: _____ Zip: _____
Phone: HOME _____ WORK: _____ CELL: _____
Email Address: _____

PHOTO RELEASE (Please check one)

I DO- or I DO NOT- Consent to and authorize the use and reproduction by CHEFF THERAPEUTIC RIDING CENTER of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibits, possible use on website, or for any other use for benefit of the program.

EMERGENCY TREATMENT RELEASE

Physician's name: _____ Telephone: _____
Physician's address: _____
Health insurance provider: _____ Policy #: _____
Preferred medical facility: _____

Emergency contact (other than parent/guardian):

Name: _____ Relationship: _____
Telephone: HOME _____ OTHER _____

ALLERGIES: _____

DESCRIBE ANY MEDICAL CONDITIONS REQUIRING PRECAUTIONS/TREATMENT AND ANY MEDICATIONS WITH DOSAGE: _____

___ **I GIVE MY CONSENT:** In case of a medical emergency, the undersigned authorizes the Cheff Therapeutic Riding Center to provide such medical assistance as they determine to be necessary. The undersigned authorizes any licensed physician and/or medical facility to provide medical surgical care and/or hospitalization for the participant, including anesthetic, which they determine to be necessary or advisable, pending receipt of a specific consent from the undersigned.

OR

___ **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: _____

No participant can be accepted for riding instruction until this form has been completed by the parent/guardian if applicable. If the participant is of legal age (18), he or she may complete the form if he/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 of the organizations concerned including the Cheff Therapeutic Riding Center.

SIGNATURE: _____ **DATE:** _____
(Participant if legally able or parent/guardian)



Cheff Therapeutic Riding Center

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Tel: 269.731.4471 Fax: 269.731.2990

Liability Release Form

I agree to the following agreement with the CHEFF THERAPEUTIC RIDING CENTER, a Michigan nonprofit corporation (hereafter referred to as "Center") as a condition for allowing me, and the persons identified below, to enter the Center's premises and surrounding land, be near horses, participate in equine-assisted activities, work near horses, handle horses, use equipment, work with staff and volunteers, and/or receive instruction or guidance in riding, grooming, or handling of horses (these activities will hereafter be referred to in this document as "The Activities").

PARTICIPANT IF 18 OR PARENT/GUARDIAN _____

SPOUSE OR OTHER PARENT _____

HOME ADDRESS _____
Street City ST ZIP

PHONE (Home) _____ (Business) _____ (Cell/Other) _____

I also make this agreement on behalf of the following, who is/are my child/ren or court appointed legal ward(s):

1. _____ Age _____ Child's DOB: _____
2. _____ Age _____ Child's DOB: _____

All parts of this agreement shall apply to me and shall also apply to the children/legal wards listed above. This Release is intended to be valid and binding at **all times - now and in the future** - when Center permits me (directly or indirectly) to engage in any or all of The Activities.

IT IS HEREBY AGREED AS FOLLOWS:

1. I have requested to engage in any or all of The Activities, now and/or in the future
2. **Risks.** I understand that anyone engaging in The Activities can suffer bodily and other injuries. Participation in The Activities involved certain inherent risks and, regardless of the care that is taken, it is impossible to ensure the safety of the participant. **I understand the risks/dangers inherent in The Activities, and I agree to assume them. I am not relying on the Center to list all possible risks for me.**
3. **Waiver and Liability Release.** As consideration for Center allowing me to engage in The Activities at any time and at any location, I agree to assume full responsibility for any and all bodily injuries, losses, or damages that I may sustain. I, for my heirs, administrators, personal representatives, or assigns, release and discharge the CHEFF THERAPEUTIC RIDING CENTER, Cheff Therapy Services, and their employees, assistants, directors, volunteers, land owners, and owners of horses from any and all claims, demands, damages, actions, omissions, suits, or causes of action (present or future).

WARNING

Under the Michigan Equine Activity Liability Act [1994 P.A. 351], an equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of the equine activity.

IT IS MUTUALLY UNDERSTOOD AND AGREED THAT THE WAIVER AND LIABILITY RELEASE SET FORTH IN THIS DOCUMENT CONSTITUTES A WAIVER OF LIABILITY BEYOND THE PROVISIONS OF THE MICHIGAN EQUINE ACTIVITY LIABILITY ACT, 1994 P.A. 351. BY SIGNING THIS RELEASE, I AGREE NOT TO BRING ANY CLAIM OR SUIT AGAINST CENTER OR PERSONS OR ENTITIES WORKING ON BEHALF OF OR AFFILIATED WITH CENTER ON THE BASIS OF ANY EXCEPTION IN THAT LAW.

4. **Indemnification.** I also agree to indemnify and hold harmless the CHEFF THERAPEUTIC RIDING CENTER, Cheff Therapy Services, and persons or entities working on behalf of or affiliated with the Center against all damages which are sustained or suffered by any third persons. The indemnification shall include reimbursement of Center's attorney fees.
5. **ASTM/SEI Headgear.** CHEFF THERAPEUTIC RIDING CENTER will provide me with an equestrian safety helmet that is ASTM-standard and SEI-certified for use when riding, handling, or near horses. I understand that neither CHEFF THERAPEUTIC RIDING CENTER or its assistants or agents can guarantee the suitability of any helmet provided.
6. **Health and Disabilities.** I understand that Center always recommends that I seek the advice of a physician, and many of The Activities pose special physical risks to the participant and even to the volunteer. I want Center to be aware of the following physical conditions I have that may affect my ability to handle, ride, and/or be near an equine:

7. Should I breach this Release (or any part of it) I agree to pay the attorney's fees and court costs related to such breach incurred by Center and/or persons directly affiliated with Center. It is also mutually agreed that any disputes arising under this Release, or any activities that are undertaken pursuant to this document, shall be litigated in a court of proper jurisdiction located in or nearest to Kalamazoo County, Michigan.

SIGNATURE OF CONTRACTING PARTY _____ DATE _____

SIGNATURE OF OTHER CONTRACTING PARTY _____ DATE _____



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Physician Referral Form

Participant's name: _____ DOB: _____

Parent/Guardian name: _____

Address: _____ City: _____ Zip: _____

Phone: _____ **CURRENT HEIGHT:** _____ **CURRENT WEIGHT:** _____

200-LB WEIGHT LIMIT DEPENDANT UPON AMBULATORY STATUS, ROM, AND INSTRUCTOR DISCRETION

The Cheff Center 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 being accepted as a riding student.

NOTE: BECAUSE OF THE NATURE OF THE ACTIVITY OF HORSEBACK RIDING, NO INDIVIDUAL DIAGNOSED WITH DOWN SYNDROME CAN BE ACCEPTED FOR RIDING INSTRUCTION WITHOUT PROOF OF NEGATIVE DIAGNOSTIC X-RAY FOR ATLANTOAXIAL INSTABILITY/DISLOCATION CONDITION.

Diagnosis: _____

Date of onset: _____

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

Does this person demonstrate explosive/violent behavior or the potential for explosive/violent behavior? _____ **If Yes, please explain:** _____

Medical History: _____

Surgical Procedures: _____

Medications: _____

Defects present in: Sight Hearing Speech Balance
 Neuro-sensation Muscle Tone Coordination Mobility

Braces or assisted devices used? NO YES: _____

Is the participant ambulatory? YES NO

Comment if applicable:

Seizures: _____

Incontinence: _____

General comments: _____

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: _____

This form is valid for a period of one year from the date signed