

# *To Our New Riders: WELCOME*

Welcome to the Monmouth County Park System's SPUR sponsored therapeutic horseback riding program. Enclosed you will find the paperwork you need to enroll in our program, which is held at the Monmouth County Park System's Sunnyside Equestrian Center:

- **New Student Application**
- **Physician's Medical Form**

**The application and medical forms must be completed and returned together. Incomplete applications will be returned to you.**

The session dates and application deadlines for each 2017 riding session are given below. Those applications postmarked after the deadline will remain on file for the next available session.

	<u>Session dates</u>	<u>Applications must be postmarked by</u>
Intersession '16 - '17	November 28, 2016 - February 4, 2017	October 6, 2016
Winter	February 20, - April 15, 2017	December 8, 2016
Spring	April 29 - June 26, 2017	March 2, 2017
Summer	July 10 - September 1, 2017	May 4, 2017
Fall	September 16 - November 11, 2017	July 20, 2017

Please return your paperwork to: Monmouth County Park System Equestrian Division  
805 Newman Springs Road  
Lincroft, New Jersey 07738  
Att: Pat Bernstein

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- The fee for each eight week SPUR session is \$350. ***Do not send payment at this time.***
- Upon receipt of your completed application, you will be placed in our SPUR database and will receive availability and payment forms for the next available session.
- You will be scheduled for a specific date and time for each session, based on the availability information you provide to us. Availability and payment forms must be returned by mail, as we use postmarks to determine scheduling order.
- Scheduling is done on a first come, first served basis. Lessons fill up quickly, so it is important to return forms in a timely manner.
- In some cases, our staff may ask to schedule a meeting with a prospective rider to better plan a program for that individual.
- Financial aid scholarships are available. Please call Sunnyside Equestrian Center at 732-224-1367, extension 0#, to request an application.
- Student medical forms must be renewed by your physician each year. You will be notified of the need to update your paperwork in ample time to allow you to have your medical forms completed.

Date Received: \_\_\_\_\_

#: \_\_\_\_\_

**SPECIAL PEOPLE UNITED TO RIDE  
MONMOUTH COUNTY PARK SYSTEM  
805 Newman Springs Road, Lincroft, NJ 07738-1695  
(732) 224-1367**

**NEW STUDENT APPLICATION**

Please complete this form carefully and in detail. The more information we have, the better we can serve you.

Applicant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (day) \_\_\_\_\_ (evening) \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Disability: \_\_\_\_\_

History of Disability (onset): \_\_\_\_\_

Ambulatory status: Independent \_\_\_\_\_ Walks with assistance \_\_\_\_\_ Crutches \_\_\_\_\_ Wheelchair \_\_\_\_\_

If wheelchair is checked, can student sit unsupported with head control? Yes \_\_\_\_\_ No \_\_\_\_\_

History of Seizures: Yes \_\_\_\_\_ No \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

Applicant's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Applicant's Therapist: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of school or day program (if appropriate): \_\_\_\_\_

**Height and weight are critical for the selection of an appropriate therapy horse.**  
**NO APPLICATIONS WILL BE CONSIDERED THAT ARE RETURNED INCOMPLETE.**  
**This will not only delay the application process but may jeopardize placement**  
**into a desired riding session.**

**Medical History**

Medication: \_\_\_\_\_

For what condition(s): \_\_\_\_\_

Administration schedule: \_\_\_\_\_

Restrictions: \_\_\_\_\_

Any Vision Deficits: \_\_\_\_\_ Corrected with glasses? \_\_\_\_\_

Other relevant information: (Check) \_\_\_ Asthma \_\_\_ Diabetes \_\_\_ Skin Irritations  
\_\_\_ Dizziness/Headaches \_\_\_ Allergies \_\_\_ Heat Exhaustion \_\_\_ Sunburn

**GENERAL BACKGROUND INFORMATION**

Cognitive Level: \_\_\_\_\_

Able to understand language: Yes \_\_\_\_\_ No \_\_\_\_\_

Able to express self verbally: Yes \_\_\_\_\_ No \_\_\_\_\_

Psychosocial concerns (emotional/social patterns): \_\_\_\_\_

Are you or the participant's current day program using any behavior modification program? Yes \_\_\_\_\_ No \_\_\_\_\_

Does participant have any fears? Yes \_\_\_ No \_\_\_

Comments: \_\_\_\_\_

Previous riding experience: \_\_\_\_\_

When: \_\_\_\_\_ Where: \_\_\_\_\_

Please provide family and/or client concerns, goals and any other information you would like us to know: \_\_\_\_\_

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Monmouth County Park System and Special People United to Ride  
805 Newman Springs Road  
Lincroft, NJ 07738-1695  
(732) 224-1367

Dear Physician:

Your patient, \_\_\_\_\_ (participant's name) is interested in participating in supervised equestrian activities.

In order to safely provide this service, our operating center requests that you complete/update the attached Medical History and Physician's Statement form. Please note that the following condition may suggest precautions and contradiction to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

**ORTHOPEDIC**

Atlantoaxial Instability – include neurological symptoms  
Coxa Arthrosis  
Cranial Deficits  
Heterotopic Ossification/Myositis  
Ossification  
Joint subluxations/dislocation  
Osteoporosis  
Pathologic Fractures  
Spinal Fusion/Fixation  
Spinal Instability/Abnormalities

**NEUROLOGIC**

Hydrocephalus/Shunt  
Seizure  
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

**OTHER**

Age – under 4 years  
Indwelling Catheters  
Medications – i.e. photosensitivity  
Poor Endurance  
Skin Breakdown

**MEDICAL PSYCHOLOGICAL**

Allergies  
Animal Abuse  
Physical/Sexual/Emotional/Abuse  
Blood Pressure  
Dangerous to self or others  
Exacerbations of medical conditions  
Fire Settings  
Heart Conditions  
Hemophilia  
Medical Instability  
Migraines  
PVD  
Respiratory Compromise  
Recent Surgeries  
Substance Abuse  
Thought Control Disorders  
Weight Control Disorders

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the operating center at the address/phone indicated above.

Sincerely,

*Pat Bernstein*

Pat Bernstein  
Equestrian Program Coordinator



## Participant's Medical History & Physician's Statement

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_  
 Past/Prospective Surgeries: \_\_\_\_\_  
 Medications: \_\_\_\_\_  
 Seizure Type: \_\_\_\_\_ Controlled: Y N Date of Last Seizure: \_\_\_\_\_  
 Shunt Present: Y N Date of last revision: \_\_\_\_\_  
 Special Precaution/Needs: \_\_\_\_\_

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N  
 Braces/Assistive Devices: \_\_\_\_\_  
*For those with Down Syndrome:* AtlantoDens Interval X-rays, date: \_\_\_\_\_ Result: + -  
 Neurologic Symptoms of Atlantoaxial Instability: \_\_\_\_\_

*Please indicate current or past difficulties in the following systems/areas, including surgeries:*

	Y	N	Comments
Allergies			
Auditory			
Balance			
Cardiac			
Cognitive			
Circulatory			
Emotional/Psychological			
Immunity			
Integumentary/Skin			
Learning Disability			
Neurologic			
Muscular			
Orthopedic			
Pain			
Pulmonary			
Speech			
Tactile Sensation			
Visual			
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 above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name/Title  
 : \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address  
 : \_\_\_\_\_  
 Phone: (     ) \_\_\_\_\_ License /UPIN Number: \_\_\_\_\_

**Monmouth County Board of Recreation Commissioners  
(Monmouth County Park System)**

**Authorization for Emergency Medical Treatment**

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 the Monmouth County Park System to:

1. Secure and retain medical treatment and transportation if needed.
2. Release participant's records upon request to the authorized individual or agency involved in the medical emergency treatment.

Participant's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

In the event I cannot be reached, contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

**ALLERGIES/MEDICAL CONDITIONS/MEDICATIONS**

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**CONSENT PLAN**

I do 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. This provision will only be invoked if the person listed below is unable to be reached.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_

Participant, Parent/Legal Guardian

\_\_\_\_\_  
Parent/Legal Guardian

**BOTH PARENTS OR LEGAL GUARDIANS MUST SIGN THIS FORM**

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**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:

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Non-Consent Signature: \_\_\_\_\_

Participant, Parent/Legal Guardian

\_\_\_\_\_  
Parent/Legal Guardian

**BOTH PARENTS OR LEGAL GUARDIANS MUST SIGN THIS FORM**

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**MONMOUTH COUNTY BOARD OF RECREATION COMMISSIONERS  
(MONMOUTH COUNTY PARK SYSTEM)  
RELEASE FORM**

**LIABILITY RELEASE:**

\_\_\_\_\_ (Participant's Name) would like to participate in the therapeutic horseback-riding program of the Monmouth County Board of Recreation Commissioners. 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 for myself and for \_\_\_\_\_ (Participant's Name), intending to be legally bound, for ourselves and our heirs and assigns, executors or administrators, waive and release forever all claims for damages against the County of Monmouth, the Monmouth County Board of Recreation Commissioners, its 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 this horseback-riding program.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_  
Participant or Parent/Legal Guardian

Signature: \_\_\_\_\_  
Parent/Legal Guardian

**BOTH PARENTS OR LEGAL GUARDIAN MUST SIGN THIS FORM**

**PHOTO RELEASE:**

\_\_\_\_\_ I do not wish to have my child photographed. (No signature required if this option is checked.)

\_\_\_\_\_ I hereby consent to and authorize the use and reproduction by the Monmouth County Park System of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_  
Participant or Parent/Legal Guardian

Signature: \_\_\_\_\_  
Parent/Legal Guardian

**BOTH PARENTS OR LEGAL GUARDIAN MUST SIGN THIS FORM**

Would you be interested in having your child *featured* in a S.P.U.R. newsletter or other periodicals?

Yes \_\_\_\_\_ No \_\_\_\_\_