



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 2017-2018 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 '17 - '18	November 27, 2017 - February 3, 2018	October 5, 2017
Winter	February 19, - April 14, 2018	December 7, 2017
Spring	April 27 - June 25, 2018	March 1, 2018
Summer	July 9 – August 31, 2018	May 3, 2018
Fall	September 14 - November 10, 2018	July 19, 2018

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

- The fee for each eight week SPUR session is \$354. ***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 or dropped off in the office.
- 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.

FOR OFFICE USE ONLY

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) _____

E-mail: _____

Parent/Guardian Name: _____

Phone: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____
(Necessary to help us choose an appropriate horse for him/her to ride)

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): _____

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 ___

If yes, please describe the fear(s) and the participant's response to them: _____

How does the participant respond to feelings of frustration and/or anger? What coping mechanisms help him/her deal with these challenges?

Previous riding experience: _____

When: _____ Where: _____

MANDATORY:

Please describe family and/or client concerns, goals and any other information that will help us to plan your participant's program:

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

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

Participant, 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

Participant, 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 SPUR newsletter or other periodicals?

Yes _____ No _____