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

RETURNING STUDENT APPLICATION UPDATE

Applicant's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (day) _____ (evening) _____

E-mail: _____

Parent/Guardian Name: _____

Telephone: (day) _____ (evening) _____

Date of Birth: _____ Height: __ Weight: _____
Necessary to help us choose an appropriate horse for him or her to ride

Disability: _____

_____

History of Seizures: Yes ___ No___ Date of last seizure: _____

Applicant's Physician: _____ Phone: _____

Applicant's Therapist(s): _____ Phone: _____

Name of school or day program (if appropriate): _____

Please use the space below to inform us of any changes that have taken place since you last completed a full application. Include updates regarding; applicant's abilities, medications, behavior issues and/or behavior plans currently being implemented, general health, and any medical treatments or procedures that have taken place in the last year. Please include any information that will assist us in understanding and instructing the applicant. Do not leave this space blank. Use the back of this form for additional space.

_____

_____

_____

_____

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 _____

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

_____
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 Park System and Special People United to Ride
805 Newman Springs Road
Lincroft, NJ 07738-1695
(732) 224-1367, ext. 3#

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

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

OTHER

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

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 program director at the address/phone indicated above.

Sincerely,

Jackie West
Program Director

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: _____

Mandatory

Weight Disclosure

Must be filled out by participant's physician

Weight Policy

In relation to horse health and safety, Special People United to Ride imposes a ruling on weight allowed on the herd of horses currently being utilized in our program.

In general and according to most published pieces a horse is able to carry a percentage of its weight depending on the breed, age, and current fitness without causing pain or long lasting ill effects over a period of time.

At this time this means our riders need to be below a certain weight in order to safely participate in our program.

Exceptions can be made at the total discretion of our trained staff and expert horse health care managers at Sunnyside Equestrian center if;

a) The rider's ability to be balanced and in correct position can help the horse stay sound and stable.

b) The rider is able to ride independently so volunteers and side walkers will not be put in an unsafe position.

c) The rider can work from the ground for half hour lesson depending on whether they can walk/stand independently or with little assistance.

Rider's Name: _____

Rider's Height: _____ Weight: _____

Physicians Signature: _____