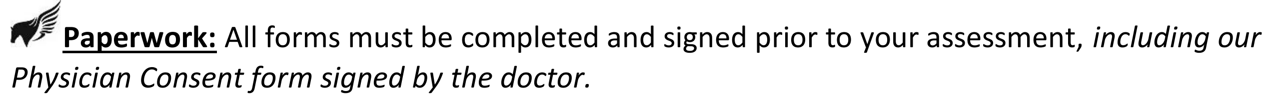
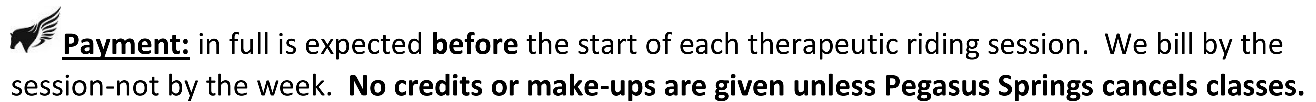
PEGASUS SPRINGS
THERAPEUTIC RIDING CENTER

Welcome!! Please read the following general information and guidelines:

Please indicate below which program you are interested in:

___ *Therapeutic Riding Lessons*
___ Grief Support *(no Physician Consent needed)*
___ *Not sure at this time*

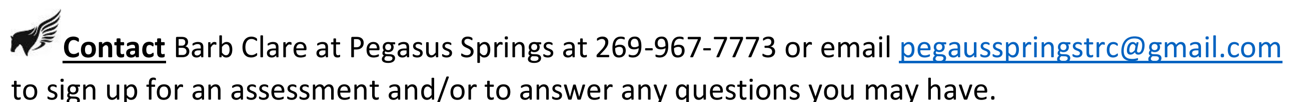

Paperwork: All forms must be completed and signed prior to your assessment, *including our Physician Consent form signed by the doctor.*


Payment: in full is expected **before** the start of each therapeutic riding session. We bill by the session-not by the week. **No credits or make-ups are given unless Pegasus Springs cancels classes.**

Classes: Many days, we schedule lessons back-to-back. Please make every effort to be at least 10 minutes early. **If you arrive more than 15 minutes late you will forfeit your ride that day.**

General Guidelines:

- Family and friends of patients are welcome to observe lessons / treatments as long as it is not a distraction. As a general rule, and for the best experience possible for your child, parents are encouraged NOT to volunteer for their child's lessons.
- Siblings are welcome, but must be under the supervision of an adult at all times.
- Please leave your pets at home, with the exception of certified service animals.


Contact Barb Clare at Pegasus Springs at 269-967-7773 or email pegausspringstrc@gmail.com to sign up for an assessment and/or to answer any questions you may have.

DISCRIMINATION DISCLOSURE

It is the policy of the Pegasus Springs Therapeutic Riding Center to provide equal opportunity for all persons and to prohibit unlawful discrimination because of age, disability, race, color, creed, religion, gender, national origin, or veteran status. This policy applies to all participants, potential participants, volunteers and employees.

IF THE TAWAS/HALE/OSCODA SCHOOLS ARE CLOSED DUE TO WEATHER, ALL LESSONS ARE AUTOMATICALLY CANCELLED

Pegasus Springs Therapeutic Riding Center

Participant Application & Health History

GENERAL INFORMATION

Participant name ____ DOB _______ Age _____

Address ____

City ____________________________________ State ____ Zip _______ County ___________

Gender: M F Height __________ Weight _________*

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

Race/Ethnicity: *American Indian/Alaska Native ____; Asian ____; Black/African American ____; Hispanic/Latino ____; Native Hawaiian/Other Pacific Islander ____; White; ____; Other ____*

This information is optional – for grant purposes only

Parent/Legal Guardian ____

Address (if different from above) ____

Email Address ____

Phone-primary: ___________________________ Phone-other (specify): _______________________

How did you hear about us?____

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: (PSTRC currently 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? ____________________

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 Pegasus Springs Therapeutic Riding Center at 269-967-7773 with any questions.

___________________________________	____________
Participant signature	Date
___________________________________	____________
Parent/Guardian signature	Date

Send completed forms to: **Barb Clare, Pegasus Springs Therapeutic Riding Center**
4800 Old State Road, National City, MI 48748

Physician Consent Form

Participant's name: ____ DOB: ____________________

Parent/Guardian name: ____

Address: _____________________________________ City: _________________________ Zip: ____________

Phone: _________________ **CURRENT <u>HEIGHT</u>**: __________ **CURRENT <u>WEIGHT</u>**: _________LBS.

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

Pegasus Springs 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: ***<u>BECAUSE OF THE NATURE OF THE ACTIVITY OF HORSEBACK RIDING, NO INDIVIDUAL DIAGNOSED WITH DOWN SYNDROME CAN BE ACCEPTED FOR RIDING INSTRUCTION WITHOUT AN ANNUAL MEDICAL CLEARANCE FROM A LICENSED PHYSICIAN THAT INCLUDES A NEUROLOGIC EXAM THAT SPECIFICALLY DENIES ANY SYMPTOMS CONSISTENT WITH ATLANTOAXIAL INSTABILITY (AAI)</u>***

Diagnosis: ____ **Date of onset**: ___________

IF DIAGNOSIS IS DOWN SYMDROME, THIS FORM MUST BE ACCOMPANIED BY A SIGNED AND DATED STATEMENT FROM THEIR PHYSICIAN THAT DENIES ANY SYMPTOMS CONSISTENT WITH AAI.

Does this person demonstrate explosive/violent behavior or the potential for explosive/violent behavior? Yes___No___ 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:

Pegasus Springs Therapeutic Riding Center

Liability Release Form & Notice of Privacy Practices

(2 pages)

I agree to the following agreement with **PEGASUS SPRINGS 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 State Zip code

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 _____ **2.**) ________________________________ Age _______

Child's DOB: _______________________ 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 PEGASUS SPRINGS THERAPEUTIC RIDING CENTER, Dennis or Barbara Clare, 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).
4. ***ASTM/SEI Headgear***. PEGASUS SPRINGS 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 PEGASUS SPRINGS THERAPEUTIC RIDING CENTER or its assistants or agents can guarantee the suitability of any helmet provided.
5. ***Health and Disabilities***. I understand that Center 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.
6. 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 Iosco County, Michigan.

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7. ***Indemnification***. I also agree to indemnify and hold harmless the PEGASUS SPRINGS THERAPEUTIC RIDING CENTER, Dennis or Barbara Clare, 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.

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.

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:

____

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 <u>NOT TO BRING ANY CLAIM OR SUIT</u> AGAINST CENTER OR PERSONS OR ENTITIES WORKING ON BEHALF OF OR AFFILIATED WITH CENTER ON THE BASIS OF ANY EXCEPTION IN THAT LAW.

SIGNATURE OF CONTRACTING PARTY ________________________________ DATE ______________

SIGNATURE OF OTHER CONTRACTING PARTY ___________________________DATE ______________

****

Date: ______________________

____ **gives permission to Pegasus Springs Therapeutic Riding Center to discuss case, or seek medical records from:** ____, **in order to better under-stand how to best serve the participant.**

____

(participant)

____

(parent/guardian) **(witness)**

****

NOTICE OF PRIVACY PRACTICES
PEGASUS SPRINGS THERAPEUTIC RIDING CENTER

I have been provided with and/or read a copy of the Notice of Privacy Practices for Pegasus Springs Therapeutic Riding Center

____ ________________________________

Signature **Date**

Pegasus Springs Therapeutic Riding Center
Photo & Emergency Treatment Release

Participant: ____ Date of birth: __________________

Parent/Guardian: ____

Address ____

Street City State ZIP

Parent/Guardian's Employer: ____

Primary Email: ____________________________________Other Email: ______________________________

Correspondence will be by Email. Do you prefer we contact you by phone instead?

☐ NO, email works fine for me ☐ YES, contact me via ph# below.

Primary Phone:____________________ (who?)____________ Other Phone: __________________ (who?)____________

PHOTO RELEASE (Please check one)

______I DO *or* ______I DO NOT Consent to and authorize the use and reproduction by PEGASUS SPRINGS THERAPEUTIC RIDING CENTER of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibits, social media or for any other use for benefit of the program.

EMERGENCY TREATMENT RELEASE

Physician's name: ______________________________________ Office Telephone: _______________________________

Physician's address: ____

Health insurance provider: _____________________________________ Policy #: _________________________________

Preferred medical facility: ____

Emergency contact (other than parent/guardian): Name: ____

Relationship:______________________________________**Phone(primary)**_________________**(other)**_______________

LIST ANY ALLERGIES: ____

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

____

____

____ **I GIVE MY CONSENT:** In case of a medical emergency, the undersigned authorizes Pegasus Springs 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 and signed. 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 Pegasus Springs Therapeutic Riding Center.

SIGNATURE: ____ **DATE:** _________________________

(Participant if legally able or parent/guardian)