



PO Box 312, Esko, MN 55733  
Ph: (218) 879-7608 Fax: (218) 879-7609  
Email: [ncride@gmail.com](mailto:ncride@gmail.com)  
Web Site: [www.northcountryride.org](http://www.northcountryride.org)

Hello and welcome to North Country RIDE.

Please use this application to apply for our **Therapeutic Riding Program** (1 hour classes once per week ages 4 and up) and **Horse Partners Program** (45 minute classes once per week ages 8 and up – no riding). Both programs are offered in 6 week sessions.

All forms and signatures must be on file before classes will be scheduled. Medical forms can be faxed to: 218-879-7609

The cost per six week session is \$175.00, which needs to be received to guarantee your spot.

All participants must dress appropriately for their classes. Everyone must wear pants and appropriate outerwear; don't forget your sunscreen. All participants must have closed toe shoes. The best shoes for riding are boots with a heel and hard toed shoes for groundwork.

All participants must have a parent/guardian/caregiver remain at the facility during lessons.

We are looking forward to another great year at North Country RIDE and seeing our friends again. I hope our website will answer most of your questions but if not, please call us. Also, don't forget to follow us on Facebook to stay up to date with current events!

*“A community where all people facing life challenges can find growth and healing through a connection with horses”*



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**Please complete scheduling options and return with your forms to our office:**

I, \_\_\_\_\_(rider name) am interested in the following program:

- Therapeutic Riding
- Companion Riding
- Horse Partners (groundwork program – no riding)

during the following session(s):

- Spring
- Summer 1
- Summer 2
- Fall

Best days and times (circle): 1<sup>st</sup> choice    M   T   W   Th    Time: AM   Afternoon   Evening

2<sup>nd</sup> choice    M   T   W   Th    Time: AM   Afternoon   Evening

I am not able to be at a lesson until after \_\_\_\_\_am/pm

I have included payment of \$\_\_\_\_\_

Please note **refunds will only be made for classes cancelled by NCR.**

Person responsible for scheduling:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Number: \_\_\_\_\_ email \_\_\_\_\_

Person responsible for billing:

Name: \_\_\_\_\_

Email (or address)\_\_\_\_\_

**Anyone billing to a County Agency must have a preauthorization for services letter sent to NCR prior to the session.**

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Participant: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Parents/Legal Guardian: \_\_\_\_\_

Parent work phone: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Are you a returning participant Yes \_\_\_\_\_ No \_\_\_\_\_

**HEALTH HISTORY**

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Please indicate current or past special needs in the following areas. If yes, please add comment:

	yes	no	comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Arm or Leg Braces			
Bone/Joint			
Muscular			
Thinking/Cognitive			
Allergies			Epi-pen?

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**MEDICATIONS** (include prescription, over-the-counter; name, dose and frequency)

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Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

**PHYSICAL FUNCTION** (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

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**PSYCHO / SOCIAL FUNCTION** (i.e. Work/school including grade completed, leisure interests, relationships – family structure, support systems, companion animals, fears/concerns, etc)

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**GOALS** (Why are you applying for participation? What would you like to accomplish?)

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**Photo Release**

I \_\_\_\_\_ DO \_\_\_\_\_ DO NOT consent to and authorize the use and reproduction by North Country RIDE of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program (this includes the website, North Country RIDE Facebook & newspapers).

**PHOTO POLICY:** Photos you take at North Country RIDE of riders/volunteers other than your child may not be posted to Facebook or other social media sites. Please respect the privacy of all participants & volunteers.

**It is our duty to advise you that equine assisted activities and horseback riding could lead to accidents that could cause injury or death.**

**Liability Release**

\_\_\_\_\_ (participant’s name) would like to participate in the North Country RIDE program activities. I acknowledge the risks and potential risks of equine assisted activities. I hereby, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages or other compensation against North Country RIDE, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my daughter/son, my ward may sustain while participating in program activities at North Country RIDE, sponsored by North Country R.I.D.E. or any activity related thereto.

\*\*\*NCR reserves the right to remove riders from the horse for reasons of safety of all participants, or as a disciplinary measure.

\_\_\_\_\_  
Consent Signature, legally competent participant, parent or legal guardian Date

\_\_\_\_\_  
Print Consenter’s Name Relationship Phone

\_\_\_\_\_  
Consenter’s Address City State Zip

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### North Country RIDE Participant Data 2018

The following information is required for some of our funding sources. Please help us supplement our program and keep the cost to our riders as low as possible.

All information is STRICTLY CONFIDENTIAL and will be used for statistical purposes only.

**Gender:** Female  Male

**Age group:**

Preschool (under 5)	<input type="checkbox"/>
Child (6-11)	<input type="checkbox"/>
Youth (12-14)	<input type="checkbox"/>
Adolescent (14-18)	<input type="checkbox"/>
Adult (19-65)	<input type="checkbox"/>
Senior (over 65)	<input type="checkbox"/>

**Racial/Ethnic Background:**

African American / black	<input type="checkbox"/>
Asian	<input type="checkbox"/>
Caucasian /white	<input type="checkbox"/>
Hispanic /Latino	<input type="checkbox"/>
Native American	<input type="checkbox"/>
Other	<input type="checkbox"/>
Prefer not to answer	<input type="checkbox"/>

**Residence by Zip Code :**

**Size of family unit:**

**Annual Income Level:**

under \$20,000	<input type="checkbox"/>
\$20,001-30,000	<input type="checkbox"/>
\$30,001-\$40,000	<input type="checkbox"/>
\$40,001-\$60,000	<input type="checkbox"/>
> \$60,000	<input type="checkbox"/>

## Physician's Statement

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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

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

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Past/Prospective Surgeries: \_\_\_\_\_

Seizures? Yes No Type: \_\_\_\_\_

Controlled? Yes No Date of Last Seizure: \_\_\_\_\_

Special Precautions/Needs: \_\_\_\_\_

Mobility: Independent \_\_\_\_\_ Cane \_\_\_\_\_ Crutches \_\_\_\_\_ Braces \_\_\_\_\_ Walker \_\_\_\_\_ Wheelchair \_\_\_\_\_

For those with **Down Syndrome**: Neurologic Symptoms of Atlantoaxial Instability \_\_\_present \_\_\_absent  
 (symptoms include changes in head control, gait, hand control, bladder or bowel function, increase muscle tone and/or fatigue)

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

Systems/Areas:	yes	no	comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Medications			
Other			

*Please See Other Side – Signature Required*

### Information for Physician

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The following conditions may suggest precautions and contraindications to equine assisted activities. Therefore, when completing this form, please note whether these conditions are present (circle) and to what degree.

**Orthopedic**

Atlantoaxial Instability  
Coxa Arthrosis  
Cranial Deficits  
Heterotopic Ossification  
Joint subluxation/dislocation  
Kyphosis  
Lordosis  
Myositis Ossificans  
Osteoporosis  
Pathologic Fractures  
Scoliosis  
Spinal Fusion/Fixation  
Spinal Instability/Abnormalities  
Spinal Orthoses  
Spinal Stabilization Devices (Internal)

**Neurologic**

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

**Medical**

Allergies  
Blood Pressure Control  
Heart Conditions  
Hemophilia  
Hypertension  
Medical Instability  
Migraines  
PVD  
Recent Surgeries  
Respiratory Compromise  
Stroke  
Varicose Veins

**Other**

Acute exacerbation of chronic disorder  
Age - less than 4 years  
Behavior Problems  
Indwelling Catheters  
Medications - i.e. photosensitivity  
Poor Endurance  
Skin Breakdown

Thank you very much for your assistance. For more information on equine assisted activities, please feel free to contact: North Country RIDE, PO Box 312, Esko, MN 55733 218-879-7608

Given the preceding diagnosis and medical information, this person is not medically precluded from participation in supervised equestrian activities. However, I understand that North Country RIDE will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to North Country RIDE for ongoing evaluation to determine eligibility for participation.

Physician Name (Please Print): \_\_\_\_\_

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

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

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

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_