NORTH COUNTRY RIDE
Find Your Stride

PO Box 312, Esko, MN 55733
Ph: (218) 879-7608 Fax: (218) 879-7609
Email: ncride@gmail.com
Web Site: 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!

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

Participants name_____

☐ **Therapeutic Riding** ☐ **Horse Partners (groundwork program – no riding)**

Circle all the sessions you want to sign up for. You will only be scheduled for the ones circled.

SPRING SUMMER 1 SUMMER 2 FALL

Circle your preferred day: (If you are doing multiple sessions and want the same day and time for each session please put a note in the comments).

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

What time of day works best? Between 9:00 -12:00_____ Between 12:00-3:00_____

Between 3:00- 7:00_____ Comments:_____

_____

Will the person attending with this participant be available to volunteer during the class time? Yes_____No_____ If yes please fill out a volunteer form from our website northcountryRIDE.org
Note to person attending with participant: we need your help if you are able.

Person responsible for scheduling:

Name _____ Relationship _____

Phone Number: _____ email_____

Person or County Responsible for Billing_____

Phone #_____email_____

Comments_____

Office use only: Monies applied: Spring_____
Summer1_____Summer2_____
Fall_____ Lollipop Fund_____

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

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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)

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)

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

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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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 North Country RIDE, I authorize North Country RIDE to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.
3. This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedures deemed "life saving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Name: _____ Phone: _____

Person to be contacted in event of emergency:

Please print clearly:

1. Contact: _____ Phone: _____
Name Relationship Home Work

2. Contact: _____ Phone: _____
Name Relationship Home Work

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____
Name City

Health Insurance Company: _____Policy #: _____

Describe any medical condition requiring special precautions or treatment:
_____
_____

Describe any medications in use & dosage:
_____

List any allergies:
_____

Date of last tetanus shot: _____

I give my consent for emergency medical treatment/aid for _____ (Participant's name) in the case of illness or injury during the process of participating in program activities or while being on the property of North Country RIDE I agree to be personally responsible for payment of any hospital clinic, laboratory, emergency room, transportation charges which are not covered by insurance.

_____
Consent Signature – legally competent participant, parent or legal guardian Relationship Date

_____ _____
Print Name Phone: Home Work

_____
Consenter's Address: Street City State, Zip Code

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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)	☐
Child (6-11)	☐
Youth (12-14)	☐
Adolescent (14-18)	☐
Adult (19-65)	☐
Senior (over 65)	☐

Racial/Ethnic Background:

African American / black	☐
Asian	☐
Caucasian /white	☐
Hispanic /Latino	☐
Native American	☐
Other	☐
Prefer not to answer	☐

Residence by Zip Code : ☐

Size of family unit: ☐

Annual Income Level:

under $20,000	☐
$20,001-30,000	☐
$30,001-$40,000	☐
$40,001-$60,000	☐
> $60,000	☐

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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: (_____)_____