



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.rideforncr.org](http://www.rideforncr.org)

## SCEDULING OPTIONS

Participant's name\_\_\_\_\_

Circle the sessions you are signing up for.

**SPRING    SUMMER 1    SUMMER 2    FALL**

\_\_\_\_**Special O** must be scheduled for Spring and Summer 1 to participate

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? Morning 9:00 -12:00\_\_\_\_\_ Afternoon 12:00-3:00\_\_\_\_\_ Evening (after work or school) 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\_\_\_\_\_

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

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F O Height: \_\_\_\_\_ Weight: \_\_\_\_\_ (200 lb. riding limit)

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

1st Phone \_\_\_\_\_ 2nd Phone: \_\_\_\_\_

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

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

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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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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**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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**Mental Function** (What area in your mental wellness are you looking to better, being with horses?)

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

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Notes by staff:

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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.

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Consent Signature, legally competent participant, parent or legal guardian

Date

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Print Consenter's Name

Relationship

Phone

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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 of participant: \_\_\_\_\_ Age: \_\_\_\_\_

### 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

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:**

(under 5)	<input type="checkbox"/>
(6-13)	<input type="checkbox"/>
(14-18)	<input type="checkbox"/>
(19-59)	<input type="checkbox"/>
(60 +)	<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"/>

**Residence by County**

**Years attending NCR**

**Annual Income Level:**

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

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## Physician's Statement

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

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

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

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			

*Signature Required*

**Information for Physician**

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





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