Our Mission: Assisting individuals to develop their highest potential through therapeutically based equine activities.
Lothlorien Therapeutic Riding Center, Inc. is a 501(c)(3) non-profit organization.

Lothlorien
Therapeutic Riding Center, Inc.
15 Reiter Road, East Aurora, NY 14052
Ph 716-655-1335 Fax 716-655-2972 lothlorientrc.org

REGISTRATION PACKET

Welcome to Lothlorien Therapeutic Riding Center!

Thank you for your interest in participating in therapeutic/adaptive riding lessons at Lothlorien Therapeutic Riding Center, Inc. (LTRC). A 501(c)(3) non-profit organization, LTRC has been providing therapeutic riding and other equine assisted activities to Western New Yorkers since 1983. Therapeutic/adapted lessons are planned around the needs of the individual participant, including their educational, physical, social and/or recreational goals.

REGISTRATION PROCESS:

1. Call 716-949-3551 to register for lesson(s). Reservations prior to each session is required. Participants may register for multiple sessions. A $50 deposit for each session is requested as soon as possible after registering. Cash, money order, check (payable to Lothlorien TRC) only. Send to Lothlorien TRC, 15 Reiter Road, East Aurora, NY 14052. Balance is due on or before first lesson. Therapeutic riding is not covered through private insurance/Medicaid.

2. Complete and sign the six (6) enclosed forms and return to LTRC two weeks prior to the first lesson. <u>These forms are valid for the current year only and must be updated each calendar year.</u> ***Participation is not possible until required forms are complete and on file.***

Policies to keep in mind: (You will receive a complete participant manual when you register.)

- LTRC does not offer make-ups, refunds, credits or pro-rates for lessons missed by the rider for any reason
- Payments are non-refundable except in a circumstance when LTRC cancels a lesson or session OR determines that the participant is not suited for horseback riding lessons due to safety concerns, behavior, change in health status, riding contraindication, etc.
- Lessons are reserved on a first come, first serve basis. Placement in a session does not carry over to the next session. Please note the beginning and end of the session(s) you are participating in.
- The acceptance and continuation of a participant depends on the availability of instructors, volunteers and suitable horses.
- Rider weight limit is a 200 pound maximum and subject to LTRC's weight policy and horse/volunteer availability
- LTRC retains the right at any time to refuse any participant that we cannot safely accommodate
- We ask participants to inform us of any changes in health status
- When near/on horses, participants must wear ASTM-approved riding helmets, which LTRC supplies.
- Lesson days, times, instructors and horses are subject to change.
- Appropriate clothing and footwear is required
- If necessary, new participants may be asked to attend a screening to facilitate our staff in determining a suitable mount, volunteers or adaptive equipment. This process is free of charge.

15 Reiter Road, East Aurora, NY 14052
Ph: 716-655-1335 • Fax: 716-655-2972
Email: program.ltrc@gmail.com • www.lothlorientrc.org

Form 1: Participant Application & Contact Information

Date: _____

PARTICIPANT CONTACT INFORMATION:

Name: _____ D.O.B: _____

Age: _____ HEIGHT: _____ WEIGHT: _____ (REQUIRED)

Address: _____ City/ST/ZIP: _____

Best number to reach you (circle one): Home Cell Work _____

If cell, OK to text you? YES NO

E-mail: _____ No email _____

School/Organization Attending: _____ Grade level: _____

PARENT/LEGAL GUARDIAN/AUTHORIZED CAREGIVER CONTACT INFORMATION:

Name: _____

Address: _____ City/ST/ZIP: _____

Best number to reach you (circle one): Home Cell Work _____

If cell, OK to text you? YES NO

Email:_____ Relationship to participant: _____

For LTRC correspondence, it is best to: (check one)

___ Contact **PARTICIPANT** at # listed above ____ Contact **PARENT/GUARDIAN** at # listed above

___ Contact the following person _____ at this phone number _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Physician's Name: _____ Phone: _____

Form 2: Participant Health History & Goals

NAME: _____ **DOB:** _____

DIAGNOSIS: _____ **Date of Onset:** _____

PHYSICAL FUNCTION: Describe participant's abilities/difficulties, including assistance required or equipment used (i.e. mobility skills - transfers, walking, range of motion, wheelchair use, etc), sensory issues, cognitive/processing or behavioral concerns, problem solving, following directions, attention span, etc.

_____
_____
_____
_____
_____

Describe general balance: _____

SOCIAL FUNCTION: Daily routines at work/school, favorite music, colors, activities, etc, family structure, support systems, companion animals, fear/concerns, likes/dislikes, etc.

_____
_____
_____
_____
_____

PERSONALITY PROFILE:

Personality/strengths: _____

Favorite activities/topics: _____

Fears/dislikes: _____

Behavioral/social issues: _____

Signs participant is becoming frustrated: _____

Successful intervention strategies at home/school (reward system, behavior reminders, sensory modalities, etc.):

_____

GOALS: Describe what personal goals or skills you would like to achieve. How can LTRC help you? Socialization, recreation, improve sensory awareness, increase core strength, have fun, etc.

_____
_____
_____
_____
_____

PAST RIDING EXPERIENCE:

_____

Form 3: Emergency Medical Treatment Authorization

Name: _____ D.O.B: _____

Address: _____ City/ST/ZIP: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Physician's Name: _____ Preferred Medical Facility:_____

Allergies (medications, latex, bee stings, etc): _____

Current medications: _____

Parent/legal guardian/authorized caregiver must remain on site at all times during equine-assisted activities.

CHOOSE ONE:

CONSENT PLAN

In the event emergency medical aid/treatment is required due to illness or injury during the process of working with and around horses, volunteering or while on the property of the agency, I authorize Lothlorien Therapeutic Riding Center, Inc to secure and retain medical treatment and transportation if needed and release my records upon request to the authorized individual or agency involved in the emergency medical treatment. This authorization includes X-rays, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the emergency contact(s) above cannot be reached.

Consent Signature: _____ Date: _____

Participant or Parent/Guardian (if under 18)

NON-CONSENT PLAN

I DO NOT give my permission for emergency medical aid/treatment if required due to illness or injury during the process of working with and around horses, volunteering or while on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

Non-Consent Signature: _____ Date: _____

Participant or Parent/Guardian (if under 18)

Form 4: Liability & Media Release

RELEASES:

There are 2 releases on this page. Please sign and date each release.

LIABILITY RELEASE AND HOLD HARMLESS AGREEMENT

I _____ (participant's name), would like to participate in riding lessons and horse related activities at Lothlorien Therapeutic Riding Center, Inc. (LTRC). I acknowledge the risks and potential for risks in riding, horse-related activities and/or being around horses, but I feel that the possible benefits to me/my child/my ward are greater than the risks assumed. These risks include, but are not limited to bodily injury, permanent disability, physical harm to rider, horse and spectator, and even death. I further understand that the horse is a prey animal and regardless of its calm nature and training, the horse will revert to its natural instinct to fight or flee when frightened. These actions may include, but are not limited to changing speed or direction at will, shifting its weight, bucking, rearing, kicking, biting or running from danger. I further understand that LTRC and its representatives are not responsible for acts, occurrences, or elements of nature which include, but are not limited to thunder, lightning, rain, snow, wind, and irregular footing which is subject to constant change in condition according to weather, temperature, usage, and natural and man-made changes in landscape. However, I feel that the possible benefits to myself/my child/my ward are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs, assigns, executors and/or administrators, waive and release forever all claims for damages against LTRC, its Board of Directors, Advisory Board, Instructors, Therapists, Aides, volunteers, employees, agents and representatives of any kind for any and all injuries, damages, claims, demands, causes of actions, lawsuits and/or losses I/my child/my ward may sustain while participating in LTRC's program.

Signature: _____ Date: _____

Participant or Parent/Guardian (if under 18)

MEDIA RELEASE:

I _____ (print name) **Check one: DO ____ DO NOT _____**

consent to and authorize the use and reproduction by LTRC of any and all audio/visual materials taken of me/my child/my ward for all promotional materials, including, but not limited to, the reproduction of photographs, audio, video, testimonials and any other materials for our use in print, LTRC website, FaceBook page, educational activities, for grant purposes, or for any other use for the benefit of the program.

Signature_____ Date: _____

Participant or Parent/Guardian (if under 18)

Form 5: Participant Medical Clearance **Date: _____**

To be completed by Physician

Participant: _____ D.O.B: _____ Age: _____

HEIGHT: _____ WEIGHT: _____ (REQUIRED)

Diagnosis: _____ Date of Onset: _____

Current Medications: _____ Allergies: _____

Seizure Type: _____ Controlled: **Y N** Date of Last Seizure: _____

Shunt Present: **Y N** Date of last revision: _____

Special Precautions/Needs: _____

Mobility: Independent Ambulation? **Y N** Assisted Ambulation? **Y N** Wheelchair? **Y N**

Braces/Assistive Devices: _____

Please indicate current or past deficits in the following systems/areas, including surgeries:	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Skills			
Cognitive			
Emotional/Psychological			
Pain Tolerance			
Other			

Applicants with Down Syndrome: Atlanto Dens Interval X-rays taken on (date): _____

Result: Positive Negative (circle one)

Form 6: Physician Statement

To be completed and signed by Physician

Participant's Name: _____ DOB: _____

The following conditions, if present, may represent precautions and contraindications to therapeutic horseback riding.
Please circle below any of the following conditions present:

Orthopedic
Atlantoaxial Instability, neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Hip or Joint Subluxation & Dislocation
Internal Spinal Stabilization Devices
Kyphosis
Lordosis
Osteogenesis Imperfecta
Osteoporosis
Pathologic Fractures
Scoliosis
Spinal Fusion/Fixation
Spinal Instabilities/Abnormalities
Spinal Orthoses

Neurologic
Chiari II Malformation
Hydrocephalus/shunt
Hydromyelia
Paralysis due to Spinal Cord Injury
Seizure Disorders
Seizure Disorders
Spina Bifida
Tethered Cord

Medical/Psychological
Allergies
Animal Abuse
Blood Pressure Control
Cancer
Dangerous to self or others
Diabetes
Exacerbations of medical conditions
Fire Settings
Hemophilia
Hypertension
Medical Instability
Migraines
Poor Endurance
Peripheral Vascular Disease
Physical/Sexual/Emotional Abuse
Poor Endurance
PVD
Recent Surgery
Respiratory Compromise
Serious Heart Condition
Stroke (CVA)
Substance Abuse
Thought Control Disorders
Weight Control Disorders
Varicose Veins

Other
Acute exacerbation of chronic disorder • Indwelling catheter • Behavior Problems • Hydromyelia • Failure to Thrive • Feeding Tube

Physician's Statement: To my knowledge there is no reason why the above named patient cannot participate in supervised equestrian activities. However, I understand that Lothlorien Therapeutic Riding Center Inc. will weigh the medical information above against any existing precautions and/or contraindications before accepting this person for therapeutic horseback riding lessons. I concur with a review if needed of this person's abilities/limitations by a licensed/credentialed health professional (e.g. physical therapist, occupational therapist, speech therapist, psychologist etc.) for the implementation of a safe and effective equestrian program.

Physician Signature: _____ Date: _____

Print Name: _____ Phone: _____

Address: _____ City/ST/ZIP: _____