

HORSES HELPING PEOPLE

Blue Heaven

Therapeutic Riding Academy, Inc

PO Box 312 * Eagle Creek OR. 97022 *

Email: carrie@blueheavenacademy.org

Phone (503) 630-2250 * www.blueheavenacademy.org

I'D RATHER BE ON A HORSE THAN ON DRUGS!

Dear new client;

Thank you for choosing Blue Heaven for your therapy needs. The following are some of our procedures for your review. In this packet you will find "Liability Release" form "Emergency Release" form Notice of Reporting Mandate/Permission to Reveal or Obtain Confidential Information". These three forms must be filled out before the new client can ride. Along with the above are the "Doctors Forms" this form must be filled out completely by your attending physician and returned to Blue Heaven 30 days from the sign up date. These forms are extremely important for our insurance and to better serve our client.

1. Clients should whenever possible wear leather boots with a heel. The leather protects feet from horse hoofs and the heel protects feet from slipping through the stirrup when riding.
2. Long pants are always recommended. Pants should never be tight.
3. All riders must wear a certified helmet. Blue Heaven can provide these helmets;
4. Payment is due the day services are rendered. If you must cancel a session a 24 hour notice is required. If no 24 hour notice is received, you will be charged the full amount of the session which is \$44.50 regardless of your pay schedule.
5. Everyone must stay clear of the horses exiting and entering the arena. If siblings of riders are present, parents must keep track of them so no one gets hurt.
6. If you love the Horses, Zoie (our collie) and Baby (our goat) please don't feed them. They are all on diets except maybe Baby who eats all day long.
7. No running in the barn or loud noises. This distracts from the client on the horse and it can also spook the horses.
8. Blue Heaven is closed every December because of everyone's busy schedule.

We are committed to the very best horse therapy or Hippotherapy (Hippo coming from the ancient Greeks meaning horse) available. We hope our clients benefit greatly from our experience and caring. Safety is the first priority but we still want an enjoyable session.

Sincerely,

Blue Heaven Therapeutic Riding Academy, Inc.

I have read the above and agree to these procedures.

Client Signature

Date

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Name: _____ Date Started: _____

Parent or Guardians Name: _____ DOB: _____

Address: _____ City: _____ State/Zip _____

Phone (H): _____ (W): _____ Cell/Pager: _____

Do you know any current riders?: _____ Email _____

Liability Release:

I, the undersigned, understand that participation in any form of equestrian sport, including any equine therapeutic activities, carries with it a risk of serious injury and even death. I am fully aware of such risks and choose to ride at Blue Heaven Academy, and participate in its activities with full knowledge of that risk.

I, the undersigned, warrant and agree that I will make no claim or suit for any injury to person or property, or for any loss or destruction of any article of any kind or nature in connection with my participation in any Blue Heaven Academy, activity.

I understand that at any time a participant creates a dangerous situation for the horse, to the side walkers or to themselves that session will be immediately terminated and the rider will be dismounted at once.

I understand that neither the Blue Heaven Therapeutic Riding Academy, Inc., nor their Directors and their staff, accepts any responsibility to accidents, damage, injury, death, or illness to the vaulters, riders, horses, owners, members, sponsors, agents, spectators or any other person or property owner in connection with this therapeutic equestrian program.

Name (Please Print): _____

Signature: _____ Date: _____

Signature of legal guardian (if participant is a minor) _____

**

Photo Release: Optional

I hereby consent to and authorize the use and reproduction by Blue Heaven Therapeutic Riding Academy, Inc. of any and all photographs and any other audio/visual materials taken of me/my son or daughter/my ward for promotional printed material, education activities of for any other use for the benefit of the above program. At no time will my Childs name or group affiliation be revealed.

Name (Please Print): _____

Signature: _____ Date: _____

Signature of legal guardian (if participant is a minor) _____

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**EMERGENCY MEDICAL
RELEASE FORM**

Notice to all participants
This form must be completed!

NAME: _____

SOC. SEC. # _____ - _____ - _____

ADDRESS: _____

HOME PHONE: _____

WORK PHONE: _____

Person to contact in case of emergency:

NAME: _____

PHONE: _____

MED. INS. CO. _____

POLICY NO. _____

PERTINENT MEDICAL HISTORY: _____

ALLERGIES: _____

CONTACT LENSES: YES _____ NO _____

MEDICAL DOCTORS NAME: _____

DATE OF LAST TETNUS SHOT: _____

OTHER MEDICAL INFORMATION: _____

Notice to parents and guardians

In many situations, a minor child cannot receive emergency medical care without the authorization of a parent or guardian. This release, if required, will be available to medical personnel in the event that you are not personally accompanying your child.

Release for an adult participant

If emergency medical care is required for myself and if I am not able to convey permission in a timely manner, the undersigned authorizes appropriate emergency medical care as deemed necessary by emergency medical personnel, a physician or the medical facility providing treatment.

I have read this entire release and agree to it.

Signature _____

Date: _____

Release for a minor

If emergency medical care is required for (Childs Name) _____

and if any permission is not available in a timely manner, the undersigned authorizes appropriate emergency medical care as deemed necessary by emergency medical personnel, a physician or the medical facility providing treatment.

I have read this entire release and agree to it in full.

Signature: _____

Date: _____

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NOTICE OF REPORTING MANDATE

By my signature, I acknowledge that information given while a client of Blue Heaven Therapeutic Riding Academy, Inc. is confidential; however, if knowledge of abuse or intention to hurt myself or others becomes known to my equestrian team, I understand that it will be reported immediately to the appropriate agencies. I also understand that my equestrian team is working the supervision of Good Samaritan Ministries, and that my case may be shared with my team's director.

CLIENTS NAME: _____

DATE OF BIRTH: _____

SIGNATURE _____ **(Parent or Guardian if client is a minor)**

PERMISSION TO REVEAL OR OBTAIN CONFIDENTIAL INFORMATION

I give Blue Heaven Therapeutic Riding Academy, Inc.; consent to obtain information, or to give information to the following agency and/or person about.....

CLIENT NAME

DATE OF BIRTH

If client is a minor, I am legally responsible in granting such permission, I understand that such information will remain confidential and that such information will be used for the benefit of the client named above.

SIGNATURE (Parent or Guardian if minor) (Date)

I have explained this packet to _____
(Name of responsible party)

Staff Signature

Date

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DOCTORS FORMS

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PATIENT NAME: _____ DATE: _____

*DIAGNOSIS: _____ DATE OF ONSET: _____

*PRECAUTIONS: _____

* Required

WHAT IMPROVEMNETS WOULD BEST HELP YOUR PATIENT?

Please check all that apply

- _____ Normalized Muscle tone
- _____ Improved balance
- _____ Improve coordination
- _____ Improve trunk mobility
- _____ Increase trunk stability

- _____ Improve head control
- _____ Gait training Explain: _____
- _____ Other _____

CONTRAINDICATIONS

- Acute herniated disc
- Atlanto-axial instability
- Coxo arthrosis (degeneration of the hip)
- Uncontrolled Seizures
- Drug dosages causing physical states inappropriate to a riding environment
- CVA – Secondary to unclipped aneurysm, or presence of other aneurysms.
- Secondary to angioxma that was not totally resected
- Acute stage of Arthritis
- Exacerbation of Multiple Scierosis
- Hemophillia
- Acute stage of Arthritis
- Open pressure sores/wounds on contact surfaces
- Anti=coagulant medication
- Pathological fractures (e.g. osteogenesis imperfacta)
- Spinal fusion, organic or operative (Harrington Rod)
- Structural Scoliosis greater than 25 -30
- Degrees or excessive Kyphosis of Lordosis: Hemiveribrae
- Unstable spine including subluxation of the cervical spine
- Osteoporosis (Sever)
- Spondyiolisthesis

MEDICATIONS CURRENTLY BEING USED

KNOWN SEIZURES _____ **HOW OFTEN** _____

MOST RESENT TETNUS SHOT DATE _____

PLEASE INDICATE IF PATIENT HAS A PROBLEM AND/OR SURGERIES IN ANY OF THE FOLLOWING AREAS BY CHECKING YES OR NOT. IF YES, PLEASE COMMENT. USING BACK IF NECESSARY.

DOCTOR FORM

AREAS	YES	NO	COMMENTS
Auditor			
Visual			
Speech			
Cardiac			
Circulator			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental impairment			
Psychological			
Seizure Disorder			
Other			

Mobility: Independent _____ Aided _____ Explain _____

PRESCRIPTION

This is a requirement for Blue Heaven

Blue Heaven Hippotherapy/Therapeutic Riding: _____ X per week, for _____ Months.

Other Therapy currently attending: _____

How often: _____

In my opinion this patient can participate in supervised equestrian activities. In conjunction with these activities I concur in the referral of the patient to a physical/occupational therapist or other health care professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program.

PHYSICIAN NAME (Please print) _____ DATE _____

PHYSICIAN SIGNATURE: _____

ADDRESS: _____

Muscle Tone: **Head/Neck** **Trunk** **Upper Extremities** **Lower Extremities**

Hypotonic				
Hypertonic				
Fluctuating:				
Other:				

DOCTOR FORM

COGNITION/PERCEPTION/BEHAVIOR

Hearing _____ Vision: _____

Frustration Tolerance: _____

Attention Span: _____

Cooperation: _____

Impulse Control: _____

Any pain: _____

Comments: _____

VISION

Please provide us with any information regarding vision that would pertain to Hippotherapy.

EQUILIBRIUM REACTIONS:

If different than normal please comment: _____

PROTECTIVE EXTENSION REACTIONS:

If different than normal, please comment: _____

Thank you for taking the time to complete this form. This will help us better serve your patient. If you need anything, want to request updates for your patient, or need any questions answered, please feel free to call us @ (503) 630-2250.

Carrie Perry
Blue Heaven Therapeutic Riding Academy, Inc.
Executive Director/Founder

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CLIENT PAY SCHEDULE

NAME: _____

ADDRESS: _____

PHONE: WORK CELL

I _____(if minor, legal guardian), wish to enroll _____(name of client) in Blue Heaven Therapeutic Riding Academy, Inc. riding program. In doing so I understand the inherent risks of being in an arena and around the horses. In knowing this I release Blue Heaven of all liability due to related sessions.

Please check one of the following and complete.

- o I agree to pay \$_____ per session at the time of service unless otherwise arranged with Carrie Perry the executive director. This fee is to be paid at the time of service.
- o I have arranged for _____(name of agency) _____(phone) to pay for my riding session with Blue Heaven. Blue Heaven is to bill my provider one a month for services rendered.

I understand that if for any reason I do not show up for our session or give at least 24 hour notice of our absents I will be charged the full rate per session of \$44.50. I further understand this will be due immediately upon my no show. All inquires should be directed to Carrie Perry Blue Heavens executive director.

I also understand that a one week notice of termination is also required on my part if I wish to discontinue my scheduled classes with Blue Heaven.

Signature (if minor Legal guardian)

Date