SUNRISE CENTER NORTH

SUNRISE NORTH
THERAPEUTIC RIDING

Information & Registration Packet

SUNRISE CENTER THERAPEUTIC RIDING PROGRAM
23061 S Thomas Dillon Dr.
Channahon, IL 60410
815/260-5628

WAIVER AND RELEASE OF CLAIMS

WARNING: Under the Equine Activity Liability Act, adopted by the State of Illinois, each participant who engages in an equine activity expressly assumes the risks of engaging in and legal responsibility for injury, loss or damage to person or property resulting from the risk of equine activities.

I, _____ (Participant's Name) would like to participate in the Sunrise North Therapeutic Riding, Inc., equine assisted therapy program.

I acknowledge that anyone engaged in this program as a staff member, rider, volunteer, or bystander is assuming certain inherent risks that are an integral part of equine activities, including but not limited to:

The propensity of an equine to behave is ways that may result in injury, harm, or death to person(s) on or around them,

The unpredictability of an equine's reaction to sound, sudden movement, and unfamiliar objects, persons or other animals, or things,

Certain hazards such as surface and subsurface conditions,

Collision with other equines or objects, and

The potential for a participant to fail to maintain control over the animal or not acting within his or her ability.

Therefore I hereby, intending to be legally bound for myself, my heirs and assigns, executors, and administrators, fully assume all risks of injury or death and agree to defend, indemnify, hold harmless, and completely and unconditionally release and waiver forever all claims for damages against, and I agree not to sue (1) Sunrise North Therapeutic Riding, Inc., including its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees, and (2) the Kendall County Forest Preserve District, who operates the Ellis House Equestrian Center, for any and all injuries and/or losses I/my child/ward may sustain while participating in the Program even if due to the negligence of any of the Released Parties.

Each participant who engages in an equine activity expressly assumes the risk of and legal responsibility for injury, loss or damage to the participant or the participant's property that result from participating in an equine activity.

Having read and understand the above description of the liability of equine activities, I agree to release Sunrise North Therapeutic Riding, Inc., including its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees, and the Kendall County Forest Preserve District, from any liability except where negligence can be proven.

Signature: _____ _____Relationship to Rider: _____

Date: _____

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PARTICIPANT INFORMATION

Name:_____ DOB_____

Address:_____ Contact Phone #_____

City:_____ Is texting OK? Yes____ No_____

State:_____ Zip:_____ email:_____

Height: _____ Weight:_____(200lb weight limit) M_____ F_____

School/Work_____

Has the participant previously participated in equine activities? No_____ Yes _____

If so where and type_____

PARENT/GUARDIAN :

Name:_____ Relationship:_____

Primary Phone Number:_____ Alternative #_____

EMERGENCY CONTACT INFORMATION:

Same as above Yes_____ No_____

Name:_____ Relationship:_____

Primary Phone Number:_____ Alternative #_____

Does the participant have any LIFE THREATENING ALLERGIES (Meds. Bee stings, latex, etc) No_____ Yes_____ If yes please list:_____

PHOTO RELEASE:

I hereby consent to and authorize the use and reproduction by Sunrise Center Therapeutic Riding Program of any and all photographs and other audiovisual materials taken of me, my son, or daughter or my ward for promotional printed materials, educational activities or for any use for the benefit of Sunrise Center North Therapeutic Riding Program.

_____**Consent** _____**Do Not Consent**

Signature:_____ Date:_____

Relationship to Rider_____

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MEDICAL HISTORY and PHYSICIANS STATEMENT

TO BE COMPLETED ONLY BY A LICENSED MEDICAL PROFESSIONAL

Participant's Name_____ DOB_____

Diagnosis _____

Date of Onset_____ Past/Perspective Surgeries_____

Medication_____

Seizure Type_____ Controlled_____ Date of last Seizure_____

Shunt Present ____Yes ____No Special Precautions/Needs_____

Independent Ambulation ___Yes ___No Braces/Assistive Devices_____

PLEASE NOTE: Participants with Downs Syndrome must have a cervical x-ray that show no evidence of AAI. An additional Physicians Release is required.

OTHER PRECAUTIONS

The following conditions, although do not necessarily restrict the participant from therapeutic riding, can represent or contraindications to the benefit of therapeutic riding. Therefore, when completing this form, please note whether these conditions are present and to what degree.

ORTHOPEDIC

Spinal Fusion or Abnormalities
Atlantoaxial Instabilities (Down Syndrome)
Scoliosos, Kyphosis, Lordosis
Hip Subluxation or Dislocation
Osteoporosis
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Device

NEUROLIGICAL

Hydroencephalus/Shunt
Spina Bifida
Tethered Cord
Hydromyelia
Paralysis or Spinal Cord Injury
Seizure Disorder

MEDICAL/SURGICAL

Allergies
Cancer
Poor Endurance
Recent Surgery
Peripheral Vascular Disease
Hemophilia
Serious Heart Condition

SECONDARY CONCERNS

Under the age of Four Years Old
Acute Exacerbation of Chronic Disorder
Indwelling Catheter

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MEDICAL HISTORY and PHYSICIANS STATEMENT Pg.2

TO BE COMPLETED ONLY BY A LICENSED MEDICAL PROFESSIONAL

Participants Name_____

Please indicate if the patient has had a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please explain in the comment section.

AREAS	NO	YES	COMMENTS
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedics			
Allergies			
Psychological. Impairments			
Learning Disabilities			
Mental Impairments			
Other			

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Sunrise Center North Therapeutic Riding Program will weigh the medical information against the existing precautions and contraindications. I concur with a review of the person's abilities/limitations that this person is not medically precluded from participations in equine assisted activities and/or therapies.

NAME/TITLE_____ MD DO NP PA Other_____

SIGNATURE_____ DATE_____

ADDRESS_____CITY_____ STATE___ ZIP_____

PHONE #_____

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PARTICIPANTS ASSESSMENT and GOAL CHECKLIST

To be completed by participant, parent or guardian

Participant's Name_____DOB_____

Special Needs_____

Please describe the following areas that apply

Cognitive Disabilities_____

Physical Disabilities_____

Anxiety/Stress Issues_____

Emotional/Behavioral Issues_____

Fears_____

Hearing Loss_____

Speech_____

Vision_____

Ambulatory_____

Seizures: No_____ Yes_____ If yes, Date of Last Seizure_____

What type of Seizure _____

Frequency of Seizures_____

PLEASE NOTE: ***If the participant has not been seizure free for a period of 12 months you MUST fill out the Seizure Evaluation Form included in this packet.***

Other_____

Behaviors to encourage/discourage_____

Does the Participant have any unique issues (behavioral, social, etc.)? How do you prefer to handle typical situations? Please include modification, communication and anything else that may be pertinent to the instructor working with this participant.

_____

_____

_____

_____

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PARTICIPANTS ASSESSMENT and GOAL CHECKLIST Pg2

To assist our instructors in formulating their lesson plans, please mark at least 3 items in each category which you/your participant would like to work towards developing. Please prioritize the items with #1 being the most important.

PHYSICAL GOALS

___Improve Balance
___Improve Posture
___General Coordination
___Head Control
___Trunk Control
___Strength
___Gross Motor Skills
___Fine Motor Skills
___Muscle Tone
___Increase Range of Motion
___Sensory Integration
___Endurance
___Visual/Spatial Orientation

SOCIAL/RECREATIONAL GOALS

___Socialization
___Cooperation
___Sportsmanship
___Enjoyment
___Confidence/Self Esteem
___Communication Skills
___Attention
___ Responsibility
___Self-Sufficiency
___Social Skills Development
___Teamwork
___Respect
___Independence
___Trust
___Interpersonal Relationships

COGNITIVE/EDUCATIONAL GOALS

___Color Recognition
___Shape Recognition
___Verbalization
___Vocabulary Expansion
___Sequencing
___Spatial Awareness
___Reading Skills
A. Letter Recognition
B. Word Recognition
C. Number Recognition

What is the participant hoping to learn from this experience ?

Short Term Goal_____

_____

Long Term Goal_____

_____+

Completed By:

Name_____

Relationship to Participant_____

Address_____City_____State____

Zip_____ Phone_____