



Rider's Edge Ability Centered Horsemanship

(R.E.A.C.H.)

PARTICIPANT APPLICATION

(This form must be updated annually)

Today's date: _____

Participant's Full Name _____

Date of Birth: _____ Gender _____

Mailing Address _____

City _____ State _____ Zip _____

Phone#: Home: (____) _____ Cell: (____) _____ Work: (____) _____

Participant's email _____ T-shirt size _____

Primary Contact Person - Who should we notify of canceled classes or other timely information?

Name: _____ Email: _____

Phone#: Home:(____) _____ Cell:(____) _____ Work:(____) _____

If applicant is under 18 years old or has a legal guardian, please provide the following information:

Father/ Legal Guardian Full Name _____

Mailing Address _____

(if different from participant)

City _____ State _____ Zip _____

Phone#: Home:(____) _____ Cell:(____) _____ Work:(____) _____

Email: _____

Mother/ Legal Guardian Full Name _____

Mailing Address _____

(if different from participant)

City _____ State _____ Zip _____

Phone#: Home:(____) _____ Cell:(____) _____ Work:(____) _____

Email: _____

PARTICIPANT PROFILE

Participant's special needs (*describe briefly*):

Any specific sensitivities? _____

Any specific fears? _____

How does client express:

Happiness _____

Fear _____

Frustration _____

Anger _____

Pain _____

Favorite things _____

Previous riding or horse related experience: _____

Other activities participant is involved in: _____

Cognitive and Social Skills:

Knows left and right - Yes No Sometimes

Follows directions - 1 step 2 step 3 step Complex

Reads - Near age level Simple words Knows letters No

Counts - 1 to 10 1 to 20 1 to 100 no

Knows colors - Yes No Some

Knows shapes - Yes No Some

Understands Language: Good Fair Poor

Vocalizations: Non-verbal 2-3 words Sentences Complete Ideas

Expresses Self: Good Fair Poor

Appropriate Volume: Too soft Normal Too Loud Varies

Makes Eye Contact: Yes Sometimes No

Social Skills/Cooperation Good Fair Poor

Behavior/Emotional Stability: Good Fair Poor

Self-Confidence: Good Fair Poor

HEALTH HISTORY

(This form must be updated annually or more frequently if needed)

To be completed and signed by Participant or Parent/Guardian if participant is under 18 or has a guardian:

Participant's Name: _____

Primary diagnosis: _____

Onset (Please check one): [] Birth [] Childhood [] Adolescence [] Adulthood

Secondary: _____ Tertiary: _____

Height: _____ Weight: _____ Current on vaccinations: [] Yes [] No

Verbal: _____ yes _____ limited _____ non-verbal (Comments: _____)

Vision: _____ normal _____ impaired _____ blind (Comments: _____)

Hearing: _____ normal _____ impaired _____ deaf (Comments: _____)

Seizures: _____ NO _____ YES ****If yes, a Seizure Disclosure Statement must be completed by a physician.***

Participant is mobile with:

_____ no assistance _____ crutches/cane _____ braces _____ walker _____ wheelchair _____ other

Participant can sit:

_____ Independently _____ with minimal support _____ with maximum support _____ not at all

Please provide a brief health history, including past and current medical conditions, physical limitations and any other significant health information (use back of page if needed):

Any recent surgeries? _____ No _____ Yes If yes, please describe:

Food allergies/sensitivities or other extreme allergies: _____ No _____ Yes If yes, please describe:

Please list all current medications (use back of page if needed):

1. _____ side effects: _____

2. _____ side effects: _____

3. _____ side effects: _____

Shunt Present: _____ NO _____ YES If YES, location and date of last revision:

Location: _____ Date of last revision: _____

Indwelling or implanted devices (including catheters, feeding tubes, etc): _____ NO _____ YES, please describe type and location of device:

Type: _____ Location: _____

Cardiac Concerns: no yes, please describe: _____

Neurological Concerns: no yes, please describe: _____

Circulation Concerns: no yes, please describe: _____

Muscular Concerns: no yes, please describe: _____

Orthopedic Concerns: no yes, please describe: _____

Chronic Pain Concerns: no yes, please describe: _____

Equilibrium Concerns: no yes, please describe: _____

Skin Sensitivities: no yes, please describe: _____

Body Temperature Concerns: no yes, please describe: _____

Tactile Sensitivities: no yes, please describe: _____

Respiratory Concerns: no yes, please describe: _____

Emotional Concerns: no yes, please describe: _____

Cognitive Concerns: no yes, please describe: _____

Social Concerns: no yes, please describe: _____

Behavioral Concerns: no yes, please describe: _____

The above information is correct to the best of my knowledge. I understand that participation in any R.E.A.C.H Program also requires a physician's evaluation and signature indicating medical approval.

Signature of Adult Participant or Parent/Guardian if under 18 or have a guardian

Date

Expectations:

What does participant (parent) hope to gain through participation in REACH programs?

Goals:

Please list three goals participant (parent) would like to pursue. These can be any variety of broad or specific goals including but not limited to horseback riding goals such as “participate in a horse show” or “ride independently”, physical goals such as “walk without assistance” or “improve large motor skills,” or social/emotional goals such as “improve eye contact” or “decrease anxiety”:

1.

2.

3.

Concerns:

Please list any specific concerns participant (parent) may have about participation in REACH programs.

RELEASE OF LIABILITY

(This form must be signed and updated annually if the individual wishes to participate in any R.E.A.C.H. program)

Name of Participant: _____

I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages or otherwise against Wood's Edge Equestrian Center, Rider's Edge Ability Centered Horsemanship (R.E.A.C.H.) its Board of Directors, Officers, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in R.E.A.C.H. programs at Wood's Edge Equestrian Center.

WARNING: Under Kansas Law (K.S.A. 60-4001 through 60 – 4004), an equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities. Inherent risks of domestic animal activities include, but shall not be limited to:

1. The propensity of domestic animals to behave in ways (i.e., running, bucking, biting, kicking, shying, stumbling, rearing, falling or stepping on) that may result in an injury, harm or death to persons on or around them;
2. the unpredictability of a domestic animal's reaction to such things as sounds, sudden movement and unfamiliar objects, persons or other animals;
3. certain hazards such as surface and subsurface conditions;
4. collisions with other domestic animals or objects; and
5. the potential of a participant to act in a negligent manner that may contribute to injury to the participant or others, such as failing to maintain control over the domestic animal or not acting within such participant's ability.

Yes, I would like above named person to participate in R.E.A.C.H. at Wood's Edge Equestrian Center. If the participant is my child or ward, I have discussed this with the participant's doctor. I understand and agree that Wood's Edge, Rider's Edge Ability Centered Horsemanship (R.E.A.C.H.), its Board of Directors, Officers, Instructors, Therapists, Aides, Volunteers and/or Employees will have NO LIABILITY in the event of any accident that may occur.

No person can be accepted for participation in a Rider's Edge Ability Centered Horsemanship (R.E.A.C.H.) program at Wood's Edge Equestrian Center until this form has been completed by the parent(s)/ guardian. If the person is of legal age (18), he or she may complete the form if he or she is legally competent to do so. All activities will be under supervision and, although reasonable effort will be made to avoid any accident, Rider's Edge Ability Centered Horsemanship (R.E.A.C.H.) or Wood's Edge Equestrian Center will have NO LIABILITY.

I acknowledge that any involvement with horses is a high-risk activity. I have read this notice and release of liability and fully understand and agree with its content.

AGREED: _____
Signature of Adult Participant or Parent/Guardian if under 18 or have a guardian Date

PHOTO RELEASE

I DO OR DO NOT consent to and authorize the use and reproduction by R.E.A.C.H. of any and all photographs and audio/visual materials taken of me for promotional material or for any other use for the benefit of the program, including but not limited to: social media, publications and marketing.

Signature of Adult Participant or Parent/Guardian if under 18 or have a guardian Date

EMERGENCY MEDICAL TREATMENT
(This form must be updated annually or more frequently if needed)

Name: _____ DOB: _____

Participant's Diagnosis: _____

Describe any medical conditions requiring special consideration, including allergies or seizures, and current medications and dosage that emergency medical providers would need to know:

Physician's Name: _____ Phone: _____

PREFERRED Medical Facility: _____

Medical Insurance Carrier _____ Policy Number _____

Emergency Contact Information:

Name: _____ Relationship: _____

Preferred Phone: (____) _____ Alternate Phone: (____) _____

The following person has temporary authorization to make medical decisions if Primary Emergency Contact cannot be reached:

Name: _____ Relationship: _____

Preferred Phone: (____) _____ Alternate Phone: (____) _____

In the event emergency medical aid/treatment is required due to illness or injury while riding or being on the property of Wood's Edge Equestrian Center, I authorize R.E.A.C.H. or Wood's Edge Equestrian Center staff to secure and retain medical treatment and transportation, if needed.

I would prefer the following emergency medical procedures to take place in the event of an emergency (use back of page if needed):

Please return completed application and \$40 fee to:

R.E.A.C.H at Wood's Edge Equestrian Center
15051 W. 191st Olathe, KS 66062
reachatwoodsedge@gmail.com
Phone: (913) 660-5107