Dear Prospective Participant,

We invite you to be part of our horseback riding program. BTR is conducting classes year round and we ask that you please present a release from your medical professional or parent prior to evaluation. Our sessions are scheduled monthly for one hour a week and taught by an instructor certified by the Professional Association of Therapeutic Horsemanship International. Prior to payment we will evaluate your application to make sure that we can be of help and that your medical and/or parental consent has been provided. We will then schedule an on-site evaluation to best address your needs and goals. Our schedule is designed around yours. Just let us know what day best suits your busy life and we will try to accommodate. The following non-refundable fee options are available:

Standard Rate: Private Lessons -$62.00 per hour – Group Lessons - $50.00 per hour

Please make your payment to BTR after your one time riding evaluation at a cost of $60.00. Student scholarships are available upon request and determined by a review by the BTR Board of Directors. Please fill out the online forms and include any medical or personal information you feel will help us make your riding more fun and beneficial.

Thank you, we look forward to having you in our “BTR” family.

Linda Olson
Program Director

Bitterroot Therapeutic Riding is a 501(c)3 Charitable Non-Profit Organization
BTR, 599 Popham Lane, Corvallis, MT 59828
Phone (406) 880-6599
www.bitterrootriding.org • btr@bitterrootriding.org
Participant’s Application and Health History

GENERAL INFORMATION

Participant__________________________

DOB:__________________ Age:_______ Height:_______ Weight:_______ Gender: M ___ F ___

Address:_________________________________________ S.S.#:__________________________

Phone:_________________________________________ Alternate Phone #:____________________

Email:__________________________________________

Employer/School:________________________________

Address:________________________________________

Phone:__________________________________________

Parent/Legal Guardian:_____________________________

Address (If different from above):____________________

Phone:__________________________________________

Referral Source:__________________________________ Phone:__________________________

How did you hear about the program?______________________________________________________

HEALTH HISTORY

Diagnosis________________________________________ Date of Onset:_______________________

Please indicate current or past needs in the following areas:

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Vision</td>
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<td>Hearing</td>
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<td>Communication</td>
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<td>Heart</td>
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<td>Digestion</td>
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<td>Elimination</td>
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<td>Circulation</td>
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<td>Emotional/Mental Health</td>
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<td>Behavioral</td>
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<td>Pain</td>
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<td>Bone/Joint</td>
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<td>Muscular</td>
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<td>Thinking/Cognition</td>
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<tr>
<td>Allergies</td>
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</tbody>
</table>

Date: ____________________________
Dear Health Care Provider:

Your patient, ____________________________ (participant’s name) is interested in participating in supervised equine activities.

In order to safely provide the service, our center requests that you complete/update the attached Medical History and Physician’s Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

**Orthopedic**
- Atlantoaxial Instability – include neurological symptoms
- Coxa Arthritis
- Cranial Deficits
- Heterotopic Ossification/Myositis Ossificans
- Joint subluxation/dislocation
- Osteoporosis
- Pathologic Fractures
- Spinal Fusion/Fixation
- Spinal Instability/Abnormalities

**Medical/Psychological**
- Allergies
- Animal Abuse
- Physical/Sexual/Emotional Abuse
- Blood Pressure Control
- Dangerous to self or others
- Exacerbations of medical conditions
- Fire Settings
- Heart Conditions
- Hemophilia
- Medical Instability
- Migraines
- PVD
- Respiratory Compromise
- Recent Surgeries
- Substance Abuse
- Thought Control Disorders
- Weight Control Disorder

**Neurologic**
- Hydrocephalus/Shunt
- Seizure
- Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia

**Other**
- Age-under 4 years
- Indwelling Catheters
- Medications – i.e. photosensitivity
- Poor Endurance
- Skin Breakdown

Thank you very much for your assistance. If you have any questions or concerns regarding this patient’s participation in equine activities, please feel free to contact the center at the address/phone indicated above.
Participant’s Medical History & Physician’s Statement

Participant __________________________________________

DOB: ____________________ Age: ___________ Height: ___________ Weight: ___________ Gender: M F

Address: ____________________________________________ Date of Onset: ____________________

Diagnosis: ____________________________________________ Past/Prospective Surgeries: __________

Medications: __________________________________________

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: ____________________ For those with Downs Syndrome: AtlantoDens Interverl X-rays, date: ____________________ Result: + - Neurologic

Symptoms of AtlantoAxial Instability: ____________________

Please indicate current or past special needs in the following systems/areas, including surgeries:

<table>
<thead>
<tr>
<th>System</th>
<th>Y</th>
<th>N</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Auditory</td>
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<td>Visual</td>
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<td>Tactile Sensation</td>
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<td>Speech</td>
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<td>Circulatory</td>
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<td>Integumentary/Skin</td>
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<td>Immunity</td>
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<td>Pulmonary</td>
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</tbody>
</table>

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the PATH center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person’s abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Name/Title ____________________________ MD DO NP PA Other _________________

Signature ____________________________ Date: ____________________________

Address: ____________________________ License/UPIN Number: ________________

Phone: ____________________________
Authorization for Emergency Medical Treatment Form

Name: ___________________________  DOB: ___________________________
Address: ___________________________  S.S.#: ___________________________
Phone: ___________________________  Alternate Phone #: ___________________________
Physician’s Name: ___________________________  Facility: ___________________________
Health Insurance Company: ___________________________  Policy #: ___________________________
Allergies to Medications: ___________________________
Current Medications: ___________________________

In the event of an emergency contact:

Name: ___________________________  Relation: ___________________________  Phone: ___________________________
Name: ___________________________  Relation: ___________________________  Phone: ___________________________
Name: ___________________________  Relation: ___________________________  Phone: ___________________________

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 the agency, I authorize _______________ 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.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed “life saving” by the physician. This provision will only be invoked if the person(s) above is/are unable to be reached.

Date: ___________________________  Consent Signature: ___________________________

Client, Parent, or Legal Guardian
Signed in presence of operating center staff

Non Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date: ___________________________  Consent Signature: ___________________________

Client, Parent, or Legal Guardian
Signed in presence of operating center staff

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM.
Bitterroot Therapeutic Riding  
599 Popham Lane, Corvallis, Montana 59828  
(406) 880-6599  
btr@bitterrootriding.org

Release executed on this ______ day of ___________ 20__ by (Name) _______________________________.

Address: ________________________________ ________________________________

Phone: ___________________________________________ Date of Birth ____________________________

Herein referred to as Releasor to Bitterroot Therapeutic Riding, Don and Linda Olson, and Olson Farms of Corvallis, Montana, herein referred to as Releasee.

Releasor, being of lawful age, in consideration of being permitted to participate in horseback riding, or other related activities, does for himself, his spouse, his legal representatives, heirs, executors, administrators, and assigns, hereby release, waive and discharge Releasee, its officers, members, owners agents, representatives, lessees, insurers, their administrators, representatives, and executives of and from any and every claim, demand, action or right of whatever kind of nature, either in law or in equity arising from or by reason of any bodily injury or personal injury know or participation in horseback riding, or any other related activity in connection with horseback riding, or training, whether negligence of the Releasee’s, their employees, agents, representatives, heirs, administrators or executors.

The Releasor, being of lawful age, acknowledges and assumes all such risks associated with the use, handling, and riding or a horse, or other related activities and hereby waives and releases and forever discharges, whether by Releasor’s negligence or not, for himself, his spouse, his legal representatives, heirs, executors, administrators, and assigns, and hereby releases, waives and discharges Releasee, its officers, members, owners, lessees, insurers, their administrators, representatives and executives of and from any and every claim, demand, action or right of whatever kind of nature, either in law or in equity arising from or by reason of any bodily injury for personal injury known or unknown, death or property damage, resulting or to result from any accident, incident, or occurrence, which may occur as a result of participation in horseback riding, training, or any other related activity, or activities at the premises or Releasees, their employees, representatives, heirs, administrators or executors.

The Releasor, being of lawful age, agrees to hold the Releasee, its officers, members, owners agents, representatives, lessees, insurers, their administrators, representatives and executors harmless of and from any and every claim, demand, action or right of whatever kind or nature, either in law or in equity arising from or by reason of any bodily injury or personal injury known or unknown, death or property damages, resulting or to result from any accident, incident or occurrence, which may occur as a result of participation in horseback riding, training, or any other activities whether negligence of the Releasee’s, their employees, agents, representatives, heirs, administrators or executors, in connection with the use of the horses or equipment.

The Releasor, being of lawful age, acknowledges and agrees that the Releasee or its agents or employees have made no representation of nor assume responsibility for a particular horse being fit for a particular rider.

The Releasor, being of lawful age, further releases the Releasee, its officers, members, owners agents, representatives, lessees, insurers, or assigns from any claim whatsoever on account of first aid, treatment or service rendered the Releasor, being of lawful age, during his participation in the activities hereinbefore described.

The use of any gender herein shall be deemed to be or include the other genders, the use of the singular herein shall be deemed to be or include the plural and vice versa, and the use of any pronoun shall be deemed to be or include any other pronouns, wherever appropriate.

This release contains the entire agreement between the parties hereto and the terms of this release are contractual and not a mere recital.

Releasor, being of lawful age, further states that he has carefully read the foregoing release and knows the contents thereof and signs this release as his free act.

Releasor, being of lawful age, further acknowledges by signing the Release that there are not blanks remaining in the Release.

IN WITNESS THEREOF, Releasor, being of lawful age, has executed the Release, the day and year first above written.

Releasor: ________________________________ Witness: ________________________________

(If not of legal age, must be signed by parent or guardian.)

I have read the above release and understand all terms. I understand that this Release is a legal and binding document and affects my rights.

Releasor: ________________________________ Witness: ________________________________

(If not of legal age, must be signed by parent or guardian.)
DATE__________________________

I ____________________________ DO HEREBY APPLY FOR SCHOLARSHIP FUNDING. I UNDERSTAND THAT THE $50 EVALUATION FEE IS NOT INCLUDED IN SCHOLARSHIP FUNDING ALLOWANCES.

I CAN PAY $_______________ FOR A FOUR (4) WEEK SESSION. I AM APPLYING FOR ADDITIONAL SCHOLARSHIP FUNDING IN THE AMOUNT OF $_____________. I WILL THANKFULLY PROVIDE MY SPONSOR AND BITTERROOT THERAPEUTIC RIDING WITH A THANK YOU LETTER AND PHOTOGRAPH NO LATER THAN THE COMPLETION OF THE FOUR WEEKS.

NUMBER OF PEOPLE LIVING IN HOUSEHOLD: ____________

MONTHLY HOUSEHOLD INCOME (BEFORE TAXES & DEDUCTIONS): $______________

IS STUDENT/CLIENT RECEIVING ANY PUBLIC BENEFITS? YES______ NO______

IF YES, WHAT IS THE SOURCE?

EXTENUATING CIRCUMSTANCES:

________________________________________________________________________

________________________________________________________________________

DO YOU SUBSCRIBE TO ANY OF THE FOLLOWING:

________________________________________________________________________

SECTION 8 HOUSING ______ SCHOOL LUNCH ______
MEDICAID ______ WELFARE ______
RENTAL ASSISTANCE ______ LIEAP ______
FOOD STAMPS ______

SIGNATURE OF STUDENT/CLIENT, PARENT AND/OR GUARDIAN:

SIGN______________________________________________________________

PRINT____________________________________ DATE______________________