THE HOPE CENTER USA

2019 E. Harvest Circle
Perry ville, Mo 63775
573-517-6004

Dear Prospective Participant,

Thanks for inquiring about the the Hope Therapeutic Horsemanship Center. The possibilities are endless when it comes to the opportunities for mental and physical enhancement that can be gleaned from the back of a horse!

The Hope Therapeutic Horsemanship Center is a non-profit organization that seeks individual and corporate donations, government grants, living legacies and opportunities for fund raising events for a seven week session. The approximate cost of running this program is $950 per horse per session. This amount covers board, feed, shoes, veterinary care, lease of the facility, games, office equipment, paid staff, insurance, license fees, PATH International dues, educational materials, printing and postage, and the tack needed to equip the horses for each individual rider.

Classes are 50 minutes in length, or as the participant allows, once a week. The participant learns basic horsemanship in the first 7-week session and progresses at his or her own pace in the following sessions. Please feel free to contact us if you have any questions at all. We'd love to hear from you!

Lisa Best,
Program Director
573-517-6004

Mailing Address:
The Hope Therapeutic Horsemanship Center
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PARTICIPANT APPLICATION

Last name:_____ First Name:_____
Preferred Nickname:_____

Parent(s)/Guardian(s):_____
Address:
Street:_____ Apt#_____
City:_____ County:_____
State:_____ Zip Code:_____

Phone:
Home:(____)_____ Work:(____)_____
Cell:(____)_____ E-Mail: _____
Do you prefer text messages? ___yes ___no

Birth Date:_____ Sex: ___ M ___ F
Height: _____ Weight: _____ (used in determining equipment and horse)

Please answer the following questions regarding the Participant:

1. Participant diagnosis:_____
2. When was the participant diagnosed?_____ at birth
   ___ result of an accident _____ date of accident
   _____ other date
3. Does the participant use any of the following?
   ___ wheelchair ___walker ___other (please explain)
   ___ cane ___crutches _____
   ___ braces _____
4. Has the participant ever been involved in therapeutic horseback riding before?
   __no __yes if yes, how long?_____
5. Other extra-curricular types of therapy the participant uses or has used in the past:
   _____
   _____
6. Do you or your child have any particular goals you wish to achieve through this program? Please explain: _____
   _____

Information on this form may be used in the preparation of grant applications for program funding; however, names will be kept strictly confidential.

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Participants Authorization for Emergency Medical Treatment Form

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while on the property of the agency, I authorize The Hope Therapeutic Horsemanship Center to:

1. secure and retain medical treatment and transportation if needed
2. release client records upon request to authorized medical personnel

Participants name:_____ phone: _____
Address:_____
In the event I cannot be reached contact: _____phone:_____
or: _____phone:_____
Physicians name: _____ phone:_____
Preferred Medical Facility:_____
Health Insurance Co.:_____ Policy #:_____

Consent Plan

This authorization includes x-rays, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. The provision will only be invoked if the person below is unable to be reached.
Date: _____ Consent Signature: _____
Participant if 18 or older, parent or guardian
Print name: _____ phone: _____
Address: _____

Non-Consent Plan

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

_____
_____
Date: _____ Non-consent signature:_____
Participant if 18 or older, parent or guardian
Print name:_____ phone:_____
Address:_____

This form is valid for a period of one (1) year from date signed.
A copy of the completed medical history should be attached to this form.

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Riders Medical History and Physicians Statement

Name:_____ DOB: _____
Address:_____zip:_____
Parent/Guardian:_____
Diagnosis:_____ Date of onset:_____
** For persons with Downs Syndrome:
__ negative cervical x-ray for Atlantoaxial Instability Date of x-ray:_____
__ negative for clinical symptoms of Atlantoaxial Instability
Tetanus shot: __ no __ yes Date:_____ Hgt:_____ Wt:_____
Seizure: Type_____ Controlled_____ Date of last seizure:_____
Medications:_____

Please indicate of patient has a problem and/or surgeries in any of the following areas by checking……

	YES or NO		**If YES, please comment:**
Auditory	____	____	_____
Visual	____	____	_____
Speech	____	____	_____
Cardiac	____	____	_____
Circulatory	____	____	_____
Pulmonary	____	____	_____
Neurological	____	____	_____
Muscular	____	____	_____
Orthopedic	____	____	_____
Allergies	____	____	_____
Learning Disability	____	____	_____
Mental Impairment	____	____	_____
Psychological Impairment	____	____	_____
Other	____	____	_____

Mobility: ____ independent ambulation ____crutches ____braces ____wheelchair
____special precautions_____

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

Physician name (please print)_____Physician signature_____
Address_____ City_____State_____Zip_____
Phone_____ Date_____

This form is valid for a period of one (1) year from the date signed.

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Participant Release and Indemnification Agreement

I acknowledge and understand the inherent risks of Horse activities and that horsemanship experiences can result in injury and even death. In consideration for being accepted into the The Hope Therapeutic Horsemanship Center and for the benefits I receive from participating in the program, I, _____, (participant if 21 or older, parent or guardian) hereby consent to assume the risks of _____, (participant's) participation in the horsemanship program sponsored by The Hope Therapeutic Horsemanship Center

Accordingly, I hereby, intending to be legally bound, for myself, my heirs and assigns, executors, or administrators, waive and forever release, acquit, discharge and hold harmless, The Hope Therapeutic Horsemanship Center, the owners of the facilities and properties on which The Hope Therapeutic Horsemanship Center conducts its therapeutic horseback riding program, including, but not limited to Rick and Claire Schemel, the officers, directors, agents, employees, representatives, therapists, instructors, and volunteers, of The Hope Therapeutic Horsemanship Center and any other person associated with The Hope Therapeutic Horsemanship Center therapeutic horseback riding program, and the successors and assigns of each of them, from all manner of claims, demands and damages of every kind and nature whatsoever I may now or in the future have against these parties on account of any losses or personal injuries, physical or mental condition, known or unknown to myself and the treatment thereof, as a result of, or in any way connected with the The Hope Therapeutic Horsemanship Center therapeutic horseback riding program, or growing out of acts of omission or caused by negligence or in any way incidental to the The Hope Therapeutic Horsemanship Center therapeutic horseback riding program.

WARNING

Under Missouri law, a Horse professional is not liable for any injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities pursuant to the Revised Statutes of Missouri.

Date:_____ Signed:_____
Participant if 21 or older, parent or guardian

Witnesses:_____

_____

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Photo Release

In consideration for being accepted into the The Hope Therapeutic Horsemanship Center therapeutic horseback riding program and for the valuable benefits I receive from participating in the program and promoting the program I, _____, hereby authorize The Hope Therapeutic Horsemanship Center, its advertising agencies or the news media to have photographs, films or other audio-visual materials taken of the participant for promotional material, educational activities, exhibitions or for any other use for the benefit of the The Hope Therapeutic Horsemanship Center therapeutic horseback riding program. I hereby indemnify and hold The Hope Therapeutic Horsemanship Center harmless against any and all claims of damages arising out of the use of any such photographs or films of me or audio-visual materials containing the participants' image.

Date:_____ Signed:_____
Participant if 21 or older, parent or guardian

Witnesses:_____

_____

_____ I choose not to allow photographs, films or other audio-visual materials.

WARNING

Under Missouri law, a Horse professional is not liable for any injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities pursuant to the Revised Statutes of Missouri.

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Equestrian Helmets

SEI Certified

Meets or exceeds
ASTM F1163-01 Standards

The Hope Therapeutic Horsemanship Center requires every student to purchase their own helmet. It must be SEI Certified equestrian riding helmet.

Helmets may be purchased at Buchheit's Store in Perryville, MO as well as other tack stores in the Southeast area.