Mailing Address: P.O. Box 71, Clinton, South Carolina 29325
Physical Address: 4000 Hurricane Church Road, Clinton, South Carolina 29325

The Palmetto Equestrian Therapeutic Riding Program serves individuals with physical and mental disabilities from 3 years to adulthood. The program teaches complete horsemanship. Program staff evaluates each rider and develops goals to increase skills. Before an applicant can be considered for inclusion in the PET Riding Program, the attached forms must be completely filled out and returned to Leigh Anne Waters, the program coordinator.

- New and present riders must meet the PET Riding Program age and weight policy.
- Medical history & physician's statement must be completely filled out and signed by the applicant's physician.
- Participant's Authorization for Emergency Medical Treatment must be completed and signed by the parent/guardian.
- Participant's Application and Health History must be completed and signed by parent/guardian.

We reserve the right to refuse any rider (of any disability) based on our ability to safely accommodate his/her needs. We, also, reserve the right to refuse or discontinue any rider for whom the program is deemed by us not to be beneficial.

Age Policy- Riders must be at least 3 years of age.
Weight Policy- Staff must be able to safely manage the participant in any situation, including an emergency dismount. In addition, safety or comfort of the horse may not be compromised during mounting activities.

Riders who have a history of having grand mal seizures must present a doctor's statement verifying that the seizures are controlled. If a rider has Down Syndrome, a doctor must give written verification that the individual has no Atlantoaxial Instability within 12 months prior to application.

Mailing Address: P.O. Box 71, Clinton, South Carolina 29325
Physical Address: 4000 Hurricane Church Road, Clinton, South Carolina 29325

Checklist for Parents of Rider Applicants

Please use this checklist to assure that all required paperwork has been completed prior to submission.

_____ Rider Application Form

_____ Rider Authorization for Emergency Medical Treatment

_____ Rider's Medical History/Physician's Statement & Prescription
(to be completed by doctor's office and returned to parent for submission with other forms)

_____ Parent Agreement to Notify Form

Upon receipt of your paperwork, a representative from the the PET Riding Program will contact you to discuss the availability of space in class.

Eligibility Verification – I certify that my child/ward meets the eligibility requirements as stated on page 1.

Signature of Parent or Guardian _____
*Date_____

Mailing Address: P.O. Box 71, Clinton, South Carolina 29325
Physical Address: 4000 Hurricane Church Road, Clinton, South Carolina 29325

Rider Application Form

Rider Name _____ Date of Birth _____
Diagnosis _____ Height _____ Weight _____
Parent/Guardian Names _____
Address _____
Home Phone _____ Cell Phone _____
Work Phone _____ School rider presently attending _____
If accepted into the program, goals you would like your rider working to attain _____
_____

Liability Release

_____ (Rider's name) would like to participate in the PET Riding Program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to my son/daughter/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 against Mr. and Mrs. John Pate, the Palmetto Equestrian Therapeutic Riding Program, its' Board of Directors, Instructors, Therapists, Aides, Volunteers and/or employees for any and all injuries and/or losses my son/daughter/ward may sustain while participating in the PET Riding Program.

*Date_____ Signature _____
Parent or Guardian

Under South Carolina law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of equine activity, pursuant to Article 7, Chapter 9 of Title 47, Code of Laws of South Carolina, 1976.

Photo Release (Check One)

- o I hereby consent to and authorize the use and reproduction by the PET Riding Program, of any and all photographs and any other audio-visual materials taken of my son/daughter/ward for promotional printed material, educational activities, or for any other use for the benefit of the program.
- o I do not give my consent for the Photo Release.

*Date _____ Signature _____
Parent or Guardian

Mailing Address: P.O. Box 71, Clinton, South Carolina 29325
Physical Address: 4000 Hurricane Church Road, Clinton, South Carolina 29325

Rider's Authorization for Emergency Medical Treatment

In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving services or while being on the property of Mr. and Mrs. John Pate, I authorize the PET Riding Program to:

1. Secure and retain medical treatment and transportation if needed;
2. Release rider records upon request to the authorized individual or agency involved in the medical emergency treatment.

Rider's Name: _____ Phone: _____
Address: _____
Emergency contact: _____ Phone: _____
Physician's Name: _____
Preferred Medical Facility: _____
Health Insurance Company & Policy Number _____

Consent Plan for Emergency Medical Treatment

Print Name (Parent or Guardian) _____ Phone _____
Address (if different from rider): _____

ATTACH A COMPLETED MEDICAL HISTORY TO THIS FORM BEFORE SUBMITTING TO THE PET RIDING PROGRAM.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will be employed only if the person listed below is unable to be reached. Please list any medical conditions (asthma, allergy to medication, etc.), medical devices and medications that professionals would need to take into consideration regarding treatment.

_____
_____

Mailing Address: P.O. Box 71, Clinton, South Carolina 29325
Physical Address: 4000 Hurricane Church Road, Clinton, South Carolina 29325

Information for Physicians:

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing the form on the attached sheet, please note whether these conditions are present and to what degree.

Orthopedic Medical/Surgical

Atlantoaxial Instabilities
Coxas Arthrosis
Cranial Deficits
Heterotopic Ossification
Hip Subluxation and Dislocation
Internal Spinal Stabilization Devices
Kyphosis
Lordosis
Osteogenesis Imperfecta
Osteoporosis
Pathologic Fractures
Scoliosis
Spinal Fusion

Allergies
Cancer
Diabetes
Hemophilia
Hypertension
Peripheral Vascular Disease
Poor Endurance
Recent Surgery
Serious Heart Condition
Stroke (Cerebrovascular Accident)
Varicose Veins
Spinal Orthoses
Spinal Instabilities/Abnormalities

Neurologic Secondary Concerns

Chiari II Malformation
Hydrocephalus/shunt
Hydromyelia
Paralysis due to Spinal Cord injury
Seizure Disorders
Spina Bifida

Acute exacerbation of chronic disorder
Tethered Cord
Age under two years
Behavior problems
Indwelling catheter

Mailing Address: P.O. Box 71, Clinton, South Carolina 29325
Physical Address: 4000 Hurricane Church Road, Clinton, South Carolina 29325

Rider's Medical History and Physician's Statement

Rider's Name _____ Name of Parent/Guardian _____
Diagnosis_____ Date of Onset_____
Tetanus Shot: (check one) YES/Date _____ NO _____
Height _____ Weight _____ lbs.
Seizure Type _____ Controlled? _____ Date of last seizure _____
Medications_____

Only For Persons with Down Syndrome
Negative Cervical X-ray for Atlantoaxial Instability. Date of X-ray _____
FOR ALL RIDERS: Please indicate if patient has a problem and/or surgeries in any of the following areas by circling the items. If yes, please comment.

Auditory	Neurological
Visual	Muscular
Speech	Orthopedic
Cardiac	Allergies
Circulatory	Learning Disability
Pulmonary	Mental Impairment
Psychological impairment	Other

Mobility: Independent Ambulation _____Yes _____No Crutches _____Yes _____ No
Braces _____Yes _____ No Wheelchair _____ Yes _____ No

Please indicate any 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 given 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, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.
Physician Name (please print) _____ Date _____
Physician Signature _____
Address _____ Phone ( ) _____

Mailing Address: P.O. Box 71, Clinton, South Carolina 29325
Physical Address: 4000 Hurricane Church Road, Clinton, South Carolina 29325

Physician's Prescription

Rider's Name _____ Phone _____

Diagnosis: _____

Prescription for Therapeutic Horseback Riding

Prescription, where appropriate for evaluation and treatment by a Physical, Occupational and/or Speech Therapist in conjunction with the PET Riding Program.

Precautions (**all riders must wear helmets**) _____

_____

_____

_____

Physician's Signature _____ Date _____

Please Print, Type or Stamp

Physician's Name _____

Address _____

_____

Phone _____

Mailing Address: P.O. Box 71, Clinton, South Carolina 29325
Physical Address: 4000 Hurricane Church Road, Clinton, South Carolina 29325

Parent's Agreement to Notify

I agree to notify the PET Riding Program in the event that (rider) _____ is unable to ride for any period of time due to:

a) medical procedures
b) illness
c) injury
d) any other extenuating circumstances

during the course of the session. If (rider)_____ is unable to complete the remaining lessons in the session, then I give consent to the PET Riding Program to fill his/her positions with another rider.

Rider's Name: _____

Parent/Guardian: _____

Date: _____