

Dream Catcher of Los Angeles

Therapeutic Riding Centers

751 Oxford Avenue, Marina Del Rey, CA 90292 (310) 350-1311 A Non - Profit 501 (c) (3)
dreamcatcherlatrc@verizon.net dreamcatcherla.com (under construction) Tax ID# 26-4041070

Welcome to Dream Catcher of L.A. We look forward to working with you. Enclosed you will find some information about our program, and forms you will need to fill out and return to us before enrolling.

Please be as complete as possible when filling out the application form. We need to know about your medical background in order to provide a safe, enjoyable, and effective experience. This information is kept completely confidential.

The form, "Physician's Statement" is to be filled out by your physician. It does not require a physical exam. The physician may fax the form back to us. Most special needs can be accommodated; however, a doctor's approval is necessary to ride.

Riders are accepted into our program subject to the results of the initial evaluation and availability. As a member center of NARHA, Dream Catcher L.A. adheres to NARHA guidelines when determining the appropriateness of our program for each rider.

If you have any questions, please call me at (310 350-1311).

Sincerely,



Joan Blank
Founder

Dream Catcher of Los Angeles
Therapeutic Riding Centers

751 Oxford Avenue, Marina Del Rey, CA 90292 Tel No (310) 350-1311 Fax No (310) 823-7878

Participant's Application and Health History

General Information

Participant: _____ Date of Birth _____
Age: _____ Height _____ Weight _____ Gender: M F
Address _____ Zip _____
Tel Home: _____ work/cell _____
E-mail Address: _____
Employer/ School _____
Address: _____ Tel: _____
Name of Parent/Gardian _____
Tel Home: _____ Work _____ Cell: _____
Address (if different than above): _____
Referral Source: _____
How did you hear about the program? _____
I am a new rider: ___ Yes ___ No I am a returning rider: ___ Yes ___ No
I am a new rider and have previously ridden with another therapeutic center ___ Yes ___ No
If yes, how long? _____

Photo Release

I DO

I DO NOT

consent to and authorize the use and reproduction by Dream Catcher of L.A. Therapeutic Riding Centers of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____

Date: _____

Client, Parent, or Legal Guardian

Participant's Health History

Name _____ Diagnosis _____

Please indicate current or past difficulties in the following areas:

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Speech or communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Allergies			
Thinking/Cognition			
Other			

Please list what medications are currently being taken, including over-the-counter medication:

Describe abilities/difficulties in the following areas (include assistance required or equipment needed):

FUNCTION (i.e. Mobility skills such as transfers, walking wheelchair use, driving/bus riding)

SOCIAL (i.e. Work/school including grade completed, leisure interest, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

GOALS (i.e. Why are you applying for participation? What would you like to accomplish?)

Physician's Statement

(To be filled out completely by the Participant's Doctor)

Participant: _____ DOB: _____ Height: _____ Weight: _____
 Primary diagnosis: _____
 Secondary 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: _____

Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N
 Braces/Assistive Devices: _____

For those with Down Syndrome: AtlantoDens Internal X-rays, date: _____ Result: + -
 Neurologic Symptoms of AtlantoAxial Instability: _____

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

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

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 person's abilities/limitations by a licensed/credentialed heal professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: () _____ License/UPIN Number: _____

Information For Physician

The following conditions, if present, may represent precautions or contradictions to therapeutic horseback riding. Therefore when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathological Fractures
Coxas Arthrosis
Heterotopic Ossification
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Neurologic

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

Medical/Surgical

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

Secondary Concerns

Behavior Problems
Age under Two Years
Age Two - Four Years
Indwelling Catheter
Acute Exacerbation of
Chronic Disorder

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Authorization for Emergency Medical Treatment

Name: _____ DOB: _____ Phone: () _____

Address: _____ City _____ Zip _____

Physician's Name: _____

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 or giving services, or while being on the property of the agency, I authorize Strides Therapeutic Riding Centers, Inc. 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 unable to be reached.

Date: _____ Consent Signature: _____

Client, Parent or Legal Guardian

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 or giving 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

Dream Catcher of L.A. Therapeutic Riding Centers

RELEASE AND WAIVER

FOR AND IN CONSIDERATION of Dream Catcher of L.A. Therapeutic Riding Centers. furnishing horses, equipment and instruction (herein referred to as "the activity") and permitting _____ (name of participant) (herein referred to as "Participant") to participate in the activity at Imperial Equestrian Center 5543 Leeds Street, South Gate California 90280, the undersigned individual, being of lawful age, or if the Participant is not of legal age, then Participant and Participant's parent or legal guardian, Participant's heirs, administrators, executors, successors and assigns, waive all discharge and hold harmless all participants, volunteers or instructors involved in the activity, and their respective directors, officers, shareholders, partners, owners, agents, employees, assured, and all other persons, firms, corporations, associations or partnerships associated herewith and their heirs, executors, administrators, successors and assigns, and each of them (collective "Releasees") from all claims, demands, actions or causes of action arising out of any losses or injuries to his/her person or property, or both, which may result, be sustained, or be received by him/her as a result of Participant attending and participating in the activity.

Participant and, if applicable, Participant's parent or legal guardian, understand that by signing this Release and Waiver, Participant and, if applicable, Participant's parent or legal guardian covenant and agree that Participant, as well as assigns, will never institute any suit or action at law, or otherwise, against the Releasees, any other Participants, volunteers or instructors involved in the activity, or in any way aid in the institution or prosecution of any claim, demand, action or cause of action for damages, costs, loss of services, expenses or compensation for or on account of any damages, loss or injury either to Participant's person or property, or both, which may result from the Participant's attendance and participation in the activity, or travel or other activity associated herewith.

Participant and, if applicable, Participant's parent or legal guardian, acknowledge that by attending the above mention activity, Participant and, if applicable, Participant's parent or legal guardian, voluntarily assume(s) all risks and danger known or unknown, foreseen or unforeseen, attendant to Participant's attendance and participation in the activity. The undersigned further declare(s) and represent(s) that no promise, inducement or agreement not herein expressed has been made to the undersigned to execute this Release and Waiver, and this Release and Waiver contains the entire agreement between the parties to this Release and Waiver.

The undersigned has/have read and fully understand(s) the foregoing Release and Waiver.

Signature of Participant (if an adult)

Signature of Parent or Legal Guardian if Participant is a minor

Date