



### What is Therapeutic Horseback Riding?

Therapeutic riding uses equine-oriented activities for the purpose of contributing positively to the cognitive, physical, emotional, and social well-being of people with special needs. Therapeutic riding provides benefits in the areas of sport, recreation, education, and medicine to individuals with a wide range of disabilities.

### What are the Benefits of Therapeutic riding?

Physically, therapeutic riding can improve coordination and help normalize muscle tone. It can help improve posture and increase the functional range of motion, muscular strength, and flexibility. Perceptual motor skills and sensory motor skills may also improve. The psychological benefits for the individuals who participate include improved motivation, self-esteem, and confidence. Therapeutic riding enhances the development of cognitive skills and allows the rider to improve socialization skills and learn teamwork.

### How do I qualify to participate as a rider with Hands and Hearts for Horses?

You must:

- Be over the age of 4
- Weigh no more than 200 lbs.
- Have sufficient balance to maintain sitting on the horse
- Behave appropriately to maintain safety

### What is the cost of therapeutic riding?

For our Fall 2020 8-week term, the cost is \$320. Payment must be made in full at the beginning of the term or in 2 monthly installments. Scholarships are available for those that need financial assistance. Please contact [equine@westonwood.org](mailto:equine@westonwood.org) for the financial scholarship application.

### The following conditions ARE contraindicated for therapeutic riding:

- Structural scoliosis > 30 degrees
- Positive x-ray for Atalantoaxial Instability
- Tethered cord or Chiari II malformation
- Hip subluxation, dislocation, or degeneration
- Spinal cord injury above T6
- Uncontrolled seizures
- Indwelling catheter
- Hemophilia

### The following conditions MAY BE contraindicated for therapeutic riding:

- Osteoporosis
- Heart condition
- Varicose veins
- Recurrent pathological fractures
- Osteogenesis Imperfecta
- Diabetes
- Spina Bifida
- Spinal fusions/spinal instability
- Recent surgeries
- Lordosis or Kyphosis
- Spinal stabilization devices

Westonwood Ranch may be unable to accommodate a potential rider due to resources available and program capabilities (i.e. horses, equipment, and availability of therapist involvement, volunteers, and instructor capabilities). Westonwood Ranch follows PATH Intl. Precautions and Contraindication guidelines.

*If you have a question as to whether you may qualify to become a rider in our program, please contact Kelly Thompson at (850) 880-2220 or email [equine@westonwood.org](mailto:equine@westonwood.org)*



WESTONWOOD  
RANCH

# Westonwood Ranch, Inc. Therapeutic Riding Program Participant Registration Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Alternate Phone: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Parents/Guardian/Spouse Name: \_\_\_\_\_

Cell Phone:(\_\_\_\_) \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

School/Institution Presently Attending: \_\_\_\_\_

Physical Therapist: \_\_\_\_\_ Occupational Therapist: \_\_\_\_\_

Speech Therapist: \_\_\_\_\_ Other: \_\_\_\_\_

Preferred Payment (circle one):    Scholarship Application (included)            Private Pay

**Photo Release:** Please initial one and sign.

\_\_\_\_\_ I hereby consent to and authorize without any compensation the use and reproduction by Westonwood Ranch of any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional printed material, educational activities, or for any other use for the benefit of the program.

\_\_\_\_\_ I do NOT consent to any photograph or other audiovisual materials taken of me/my child/my ward.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(If participant is under 18 years of age)

*Liability Release:* \_\_\_\_\_ (Participant's Name) would like to participate in the Westonwood Ranch therapeutic riding program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/my child /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 against Westonwood Ranch, its Board of Directors or Trustees, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my child/my ward may sustain while participating in any Westonwood Ranch program.

I understand that for the purpose of assisting volunteers in providing safe and responsible services to students, Westonwood Ranch will release information pertaining to the student's disability as necessary.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Westonwood Ranch, Inc.**  
**Participant Emergency Medical Treatment Form**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Health Insurance Co.: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Name of Parent/Guardian/Spouse: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Please list current medications: \_\_\_\_\_

*Emergency Medical Treatment:*

In the event emergency medical aid/treatment is required due to illness or injury during participation with Westonwood Ranch or while being on the property, I authorize Westonwood Ranch to secure and retain medical treatment and transportation if needed.

**IN CASE OF EMERGENCY:**

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**Westonwood Ranch, INC.**  
**EQUINE ACTIVITY RELEASE/WAIVER, ASSUMPTION OF RISKS AND  
INDEMNIFICATION AGREEMENT AND NOTICE OF RISKS**

I, \_\_\_\_\_, do hereby:

1. RELEASE, WAIVE, DISCHARGE, AND COVENANT NOT TO SUE Westonwood Ranch Inc., its operators, horse owners, and each of them, their officers, agents, employees, leasees, volunteers and participants (all hereafter collectively referred to as RELEASEES) from any and all claims, loss, damage, and liability to the UNDERSIGNED, his/her personal representatives, assigns, heirs, next of kin, or anyone claiming through them, arising out of any liability or negligence of RELEASEES which causes the UNDERSIGNED injury, death, damages, or property damages. I HEREBY COVENANT to hold RELEASEES harmless and indemnify RELEASEES for any claim, judgment, or expense including attorney's fees and costs of litigation RELEASEES may incur arising out of my activities or presence, or travel to or from, at or on the farm, including the playground, or on the property of RELEASEES or at horse shows.

2. UNDERSTAND that my entry onto the farm or premises of RELEASEES, riding, showing, or attending horse shows involves DANGER AND RISK OF INJURY OR DEATH, that conditions of horseback riding and horses change from time to time and may become more HAZARDOUS, and that there is INHERENT DANGER in horse and riding which I appreciate and VOLUNTARILY ASSUME because I CHOOSE TO DO SO. I have observed horses and riding of the type that I seek to participate in and I have inspected the grounds, horse, and equipment provided. I further know that other riders, horses, and participants pose a danger to me; nevertheless, I VOLUNTARILY ELECT TO ACCEPT ALL RISKS connected therewith in my participation. Likewise, I understand that use of the playground and playground equipment is voluntary and that use of the equipment involves DANGER AND RISK OF INJURY OR DEATH. I have personally inspected the playground and VOLUNTARILY ELECT TO ACCEPT AND ASSUME ANY AND ALL RISKS connected therewith in my participation and the participation of my child or children.

3. I verify that no representations or inducements have been made to me to sign this Release. I further expressly agree that the foregoing RELEASE, WAIVER, AND INDEMNITY AGREEMENT is intended to be as broad and inclusive as permitted by the law of the state in which I participate in activities conducted by the RELEASEES and that if any portion thereof is held invalid, it is agreed that the balance shall, not withstanding, continue in full legal force and effect.

**WARNING**

**Under Florida law, an equine activity sponsor or 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.**

THE UNDERSIGNED HAS READ, VOLUNTARILY SIGNED, AND UNDERSTANDS THAT THIS RELEASE AND WAIVER OF ALL LIABILITY AND INDEMNITY AGREEMENT FULLY RELEASES WESTONWOOD RANCH FROM ANY LIABILITY TO THE UNDERSIGNED.

**READ CAREFULLY BEFORE SIGNING!**

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

(if participant is under 18 years of age)

# Westonwood Ranch, Inc.

## Rider's Medical History and Physician's Statement

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Parent or Guardian: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Date of Onset: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

**\*\* For Persons with Down syndrome:**

\* Negative Cervical X-ray for Atlantoaxial Instability. \_\_\_\_ Yes \_\_\_\_ No **X-ray Date:** \_\_\_\_\_

\* Negative for clinical symptoms of Atlantoaxial Instability. \_\_\_\_ Yes \_\_\_\_ No

**\*\* For Persons with Scoliosis:** Degree of Scoliosis: \_\_\_\_\_

Seizure Type \_\_\_\_\_ Controlled: \_\_\_\_ Yes \_\_\_\_ No

**Date of Last Seizure:** \_\_\_\_\_ Tetanus Shot: \_\_\_\_ Yes \_\_\_\_ No **Date:** \_\_\_\_\_

Medications: \_\_\_\_\_

Mobility	YES	NO
Independent Ambulation		
Wheel Chair		
Walker		
Crutches		
Cane		
Braces		

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 health profession (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician's Signature: \_\_\_\_\_

Physician's Name (Please Print): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking YES or NO. If YES please elaborate in comments section.

Areas	YES	NO	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# **Westonwood Ranch Therapeutic Riding Program**

## **Possible Reasons for Participant Discharge**

Please be advised of the following reasons that may lead to discharge from the riding program.

1. The client has reached all of their goals and is ready to graduate.
2. The client's potential to maintain head and neck control while riding presents a safety concern.
3. Inability to follow directions is interfering with progress toward goals.
4. Uncontrolled and/or inappropriate behavior that constitutes a safety risk to client, staff and/or horse.
5. Client exceeds weight that can safely be managed by staff, volunteers, and/or horses.
6. Any change in the client's medical, physical, cognitive, or emotional condition that makes therapeutic riding inappropriate.
7. Three scheduled appointments are missed without prior cancelation.
8. Non-payment of fees as originally agreed.

I understand and agree with the possible reasons for client discharge.

Signature of Participant or Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_



## Participant Goals

Please help us help you get the most out of your classes by filling out the following goal setting sheet.  
Thank you.

Participant name: \_\_\_\_\_

Parent name: \_\_\_\_\_

All goals are reflective of the next term. The categories are meant as a guideline and all categories may not apply to all students.

Personal riding goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physical goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Cognitive goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Social goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Long-term goal over the next year.

Goals Dated: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_