



PO Box 395
2579 Eastham Road
Shrewsbury, VT 05738
Phone: (802)

Rider Registration Packet and Schedule

Rainbow Riding Center is offering the following sessions for Spring, Summer and Fall for the 2019 season. We operate at 2579 Eastham Road in Shrewsbury, Vermont with have a wonderful staff of instructors, volunteers and a herd of kind, gentle horses. Therapeutic horsemanship is taught by our staff of certified instructors and focuses on horsemanship skills that incorporate educational, recreational, and psychosocial goals. Lessons may be private or group sessions and run for 30 minutes to an hour depending on the participants.

Prior to the first lesson an Orientation meeting may be scheduled with and instructor at the Center to get acquainted with the program and set up a lesson schedule.

Check below for the dates of these events and mark your calendars.

Session	Spring (7 Weeks)	Summer (8 Weeks)	Fall (7 Weeks)
Applications Due	April 18, 2019	June 6, 2019	July 31, 2019
Orientation	TBD	TBD	TBD
First Lesson	May 18, 2019	July 6, 2019	August 31, 2019

(Please call the Rainbow Riding Center if you can't fit into our scheduled sessions.

We try to accommodate everyone and would like to hear from you.)

Our Scheduling/Wait List Guidelines: Rainbow Riding Center requires:

- All riders submit a fully completed application packet before being considered for scheduling.
- All riders meet with an instructor at a rider orientation session before the lesson schedule is confirmed.

Rainbow Riding Center serves as many riders as we can safely and effectively accommodate. Those that we cannot accommodate, will be placed on our wait list and will be scheduled as soon as there is an appropriate opening. Staff are happy to discuss options with the riders and/or their families, but reserve the right to make the final decision regarding scheduling and placement.

Depending on a participant's needs and with respect to their safety and for the safety of our staff, volunteers and horses; participants may be scheduled for either private or group lessons, or may be offered a spot in our un-mounted program.



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An appropriate opening is defined as one where the needs of the rider will be safely and effectively met. Variables include the availability of staff, appropriate horse, volunteer assistants, and the rider's individual time constraints.



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Site Rules:

- Once all riders have been mounted and class has started, latecomers may not be admitted
- If riding lessons cannot be held due to rain or extreme heat, barn lessons may be offered instead
- Please drive slowly near the facility and park appropriately.
- No smoking is allowed on site
- No dogs are allowed on site
- Please walk, use appropriate voices and avoid sudden movements particularly near the horses
- Refrain from using umbrellas near the horses and riding arena
- Do not approach or feed any animals without permission and accompanied by Rainbow Riding Center staff.
- Closely supervise riders, siblings of riders, and visitors while waiting for, during and after the session.
- Remain outside the riding area at all times
- Ask permission from the instructor to take photos or use a flash camera

Dress requirements:

- Closed toe shoes with a heel.
- Approved helmet (provided on site)
- Shirt and jacket if weather is cool
- Pants or leggings NO shorts

Directions to Our Site:

From the Rutland Area take Rte 103 south through Cuttingsville. TURN LEFT onto Freeman Brook Road. At Stop sign at the four corners proceed straight across onto Russellville Road. Continue on this road and TURN LEFT onto Eastham Road. We are at the small gray barn on your right.

Watch for Rainbow Riding Center Signs along the way.

From the Ludlow Area take Rte 103 north towards Cuttingsville. Just beyond the railroad trestle TURN RIGHT onto Freeman Brook Road. At Stop sign at the four corners proceed straight across onto Russellville Road. Continue on this road and TURN LEFT onto Eastham Road. We are at the small gray barn on your right.



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Participant Application

Participant: _____

Diagnosis: _____

DOB: _____ Age: ____ Height: _____ Weight: _____ Gender: M F

Address: _____

Phone: _____ E-mail: _____

Employer/School: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone (if different from above): _____

How did you hear about the program? _____

Medications (include prescription, over-the-counter, name, dose and frequency)

Physical Function (i.e. mobility skills such as transfers, walking, wheelchair use)

Psycho/Social Function (i.e. work/school including grade completed, hobbies, relationships, family structure, support systems, companion animals, fears, etc)

Goals (i.e. Why are you applying? What would you like to accomplish?)

Signature: _____ Date: _____



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Participant Payment

Session Fees

Spring	Summer	Fall
5/18-7/5 (7 Weeks)	7/6-8/30 (8 Weeks)	8/31-10/11 (7 Weeks)
\$350	\$400	\$350

Name of Participant: _____

Name of Parent/ Guardian (if applicable): _____

Daytime Phone: _____

Evening Phone: _____

This session will be paid by (check all that apply):

Direct Pay (Full payment is enclosed)

Financial Assistance (application must be enclosed)

Third Party (Agency must have been contacted by you and you must have received approval)

So that Rainbow Riding can verify and arrange for payment from a Third Party, please provide the following contact information:

Agency/ school: _____

Contact Name: _____ Phone Number: _____

Mailing Address: _____

To pay Rainbow Riding Directly Mail to:

Reinbow Riding Center

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Dear Health Care Provider:

Your patient: _____ is interested in participating
in supervised equine activities. (Participant's Name)

In order to safely provide this service, we request 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 neurologic symptoms)

Coxarthrosis

Cranial defects

Heterotopic ossification/myositis ossificans

Joint subluxation/dislocation

Osteoporosis

Pathologic fractures

Spinal joint fusion/fixation

Spinal joint instability/abnormalities

Neurologic

Hydrocephalus/shunt PVD

Spina bifida/Chiari II malformation/tethered coel/hydromyeli

Seizure

Other

Age – under 4 years

Indwelling catheters/medical equipment

Medications – e.g. photosensitivity

Poor endurance

Skin breakdown

Medical/Psychological

Allergies

Animal abuse

Cardiac condition

Physical/sexual/emotional abuse

Blood pressure control

Dangerous to self or others

Exacerbations of medical conditions (e.g., RA, MS)

Fire settings

Hemophilia

Medical instability

Migraines

Respiratory compromise

Recent surgeries

Substance abuse

Thought control disorders

Weight control disorders

Thank you for your assistance.

If you have any questions or concerns regarding this patient's participation in equine-assisted activities, please feel free to contact us at the address/phone indicated above.

Sincerely, Rainbow Riding Center



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Program Physician's Statement

(This form must be signed by the participant's physician)

Participant: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____
 Diagnosis: _____ Date of onset: _____
 Past/prospective surgeries: _____
 Medications: _____
 Seizure type: _____ Controlled: Yes No Date of last seizure: _____
 Shunt present: Yes No Date of last revision: _____
 Special precautions/needs: _____

Mobility:

Independent ambulation Yes No
 Assisted ambulation Yes No
 Wheelchair Yes No
 Braces/assistive devices: _____
 For those with Down Syndrome: neurologic symptoms of atlantoaxial instability:
 AtlantoDens Interval X-rays Date: _____ Result: Positive Negative
 Neurological symptoms of Atlantoaxial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	Yes	No	Comments
Auditory			
Vision			
Tactile/sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Orthopedic			
Allergies			
Learning disability			
Cognitive			
Emotional/psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that Rainbow Riding Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Rainbow Riding Center for ongoing evaluation to determine eligibility for participation.

Name/title: _____ MD DO NP PA Other _____
 Signature: _____ Date: _____
 Address: _____ Phone: () _____
 License/UPIN Number: _____



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Authorization for Emergency Medical Treatment

_____ Participant _____ Staff _____ Volunteer

Name: _____ DOB: _____ Phone: _____

Physician's name: _____ Preferred medical facility: _____ Health insurance
co.: _____ Policy #: _____ Current allergies, medications
and health concerns: _____

In the event of an emergency:

Emergency contact 1: _____ Relationship: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Emergency contact 2: _____ Relationship: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

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 the agency, I authorize Rainbow Riding Center 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) listed cannot be reached.

Consent signature: _____ Date: _____

(Client, Parent, or Legal Guardian)

NON-CONSENT PLAN I do not give consent for emergency medical aid/treatment in the case of illness or injury and agree to be present with the participant during the process of receiving services or while being at Full Circle Farm.

Consent signature: _____ Date: _____

(Client, Parent, or Legal Guardian)



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Consent for Release of Information

I hereby authorize: _____ to release information (person or facility)
from the records of: _____

DOB: _____ (participant's name)

The information is to be released to Rainbow Riding Center for the purpose of developing an equine activity program for the above-named participant. The information to be released is indicated below:

- | | |
|---|---|
| <input type="checkbox"/> Medical history | <input type="checkbox"/> Classroom Individual Education Plan (I.E.P.) |
| <input type="checkbox"/> Physical therapy evaluation, assessment and program plan | <input type="checkbox"/> Psychosocial evaluation, assessment and program plan |
| <input type="checkbox"/> Speech therapy evaluation, assessment and program plan | <input type="checkbox"/> Cognitive-behavioral management plan |
| <input type="checkbox"/> Mental health diagnosis and treatment plan | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Individual Habilitation Plan (I.H.P.) | _____ |

This release is valid for one year and can be revoked, in writing, at my request.

Signature: _____ Date: _____

Print name: _____

Relation to participant: _____



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Liability Release

Name _____ Date of Birth _____ Today's Date _____
Address _____ City _____ State _____ Zip _____

LIABILITY RELEASE (Required): _____ (Name) would like to participate in the Rainbow Riding Center's Therapeutic Equine Program. I acknowledge the risks and potential for risks of horseback riding and related equine activities, including grievous bodily harm. 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, and administrators, waive and release forever all claims for damages against RRC, its Board of Directors, 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 the Program from whatever cause including but not limited to negligence of these released parties.

Warning: Under Vermont Law, an equine activity sponsor is not liable for an injury to, or the death of, a participant in the equine activities resulting from the inherent risks of equine activities that are obvious and necessary, Pursuant to 12 V.S.A. 1039 – added 1995, No. 136 (ADJ. Sess.), 2. The term "Equine Activity Sponsors" includes Rainbow Riding Center, Ltd, its Board of Directors, Instructors, Therapists, Aids, Volunteers, and/or all Employees.

Signature: _____ Date: _____
Client, Parent or Legal Guardian

PHOTO RELEASES

I _____ do _____ do not consent to and/or authorize the use and reproduction by Rainbow Riding Center of any and all photographs and any other audio-visual materials taken of me/my son/my daughter/my ward for the promotional use, educational activities, and exhibitions or for any other use for the benefit of the program.

I _____ do _____ do not consent to and/or authorize photos to be posted on a Social Media page such as Facebook, Twitter, etc.

I _____ do _____ do not consent to and/or authorize the use of a quote to be used in promotional material and/or posted on a social media page.

Signature: _____ Date: _____