Reinbow Riding Center
Located at 892 Tarbellville road
Belmont, VT 05730
802-236-2483
email: programs@reinbowridingcenter.org
website: reinbowridingcenter.org

Mail to: P.O. Box 395, Shrewsbury, VT 05738

Military Program Registration Packet

Reinbow Riding Center is offering riding lessons for children of military families. We operate at 892 Tarbellville Road in Belmont, 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 run for 30 minutes to an hour depending on the participants.

Reinbow Riding Center requires all riders submit a fully completed application packet before beginning our program.

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 Reinbow 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
- Shirt and jacket if weather is cool
- Approved helmet (provided on site)
- Pants or leggings **NO** shorts

Directions to Our Site:

From the Rutland Area take Rte 103 south to Jiffy Mart in East Wallingford. Just beyond Jiffy Mart TURN RIGHT and follow signs for Route 155. Stay on 155 to Belmont (3.8 miles). At the Belmont sign turn left onto Tarbellville Rd. Then turn left at drive for Reinbow Riding/Stonewall Farm (.2 miles) across from a grey house on the right. **Watch for Reinbow Riding Center Signs along the way**.

From the Ludlow Area take Rte 103 north to the blinking light in Mt. Holly. Turn left to go to Belmont. At the Belmont Store turn right onto Tarbellville Rd. In .9 miles turn right at the Reinbow Riding/Stonewall Farm sign across from a grey house. **Watch for Reinbow Riding Center Signs along the way.**

Participant Application

Participant: _____

Diagnosis: _____ *(Why therapeutic horsemanship will be good for your child)*

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

Address: _____

Phone: _____ E-mail: _____

School:_____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone (if different from above): _____

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)

_____

_____

Why do you want your child to come to Reinbow Riding Center?

_____

_____

_____

Signature: _____ Date: _____

***Reinbow Riding Center is considering holding two (2) 8-week sessions for participants in the Military Families Program this year. Session 1 would be a spring (sometime in May start) through early summer session and a second session would start sometime after July 4th through August or early fall. Please check the session you might be interested in attending. If neither works for you please note this on the OTHER line and indicate the dates that might work for you. Scheduling is at our discretion but we will try to accommodate everyone.

Session 1:_____ Session 2:_____ OTHER: _____

Health and Medical Information

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 coed/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, Reinbow Riding Center

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:
AltlantoDens 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 Reinbow Riding Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Reinbow Riding Center for ongoing evaluation to determine eligibility for participation.

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

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 Reinbow 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)

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

☐Medical history

☐Physical therapy evaluation, assessment and program plan

☐Speech therapy evaluation, assessment and program plan

☐Mental health diagnosis and treatment plan

☐Individual Habilitation Plan (I.H.P.)

☐Classroom Individual Education Plan (I.E.P.)

☐Psychosocial evaluation, assessment and program plan

☐Cognitive-behavioral management plan

☐Other:_____

_____

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

Signature: _____ Date: _____

Print name: _____

Relation to participant: _____

Liability Release

Name_____ Date of Birth _____ Today's Date _____

Address _____ City _____ State ____ Zip _____

LIABILITY RELEASE (Required): _____(Name) would like to participate in the Reinbow 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 Reinbow 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 Reinbow 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:_____

PARENT INPUT FORM

Your child will be participating in the Therapeutic Riding program at Reinbow Riding Center. In order for us to provide an individualized program for you child, could you please take a few moments to complete this parent input form. Thank you! This will be very helpful to us.

Child's Name:_____ Nickname:_____

Age:_____

My child's greatest strengths:

My child's current challenges:

My child's current interests / motivators (activities, music, toys, etc.):

What would you like to see your child accomplish through his/her participation in our riding program?

PROVIDER INPUT FORM

(If your child has been referred for participation in this program by a physician, counselor, mental health professional, teacher, etc. please have them fill out this page.)

The following student, _____, will be participating in the Therapeutic Riding program at Reinbow Riding Center. In order for us to provide a more individualized program for this student, could you please take a few moments to complete this provider input form. Thank you! This will be very helpful to us.

Student's strengths: (cognitive, social/emotional, motor, etc.):

Student's challenges: (cognitive, social/emotional, motor, etc.):

What current developmental goals (cognitive, social/emotional, motor, etc.) do you feel would best be supported through the Therapeutic Riding program?

Provider's Name:_____

Provider's Position:_____

Reinbow Riding Center

Covid-19 Acknowledgement of Risk and Acceptance of Services

I, _____ (Participant Name/or Parent/Guardian)), am aware of the risks of contracting Covid-19 while receiving face to face services from Reinbow Riding Center at this time of the on-going Covid -19 pandemic.

I am aware that face to face services increase my risk of contracting and passing on the Covid-19 or Coronavirus and agree to hold harmless Reinbow Riding Center, it's employees and all other individuals I may come in contact with during this interaction and receiving of services.

I agree to and will follow all guidelines for personal hygiene, personal safety and public safety as recommended by Reinbow Riding Center and their staff. This may include, but is not limited to, waiting in my vehicle until I am asked to enter the property in person ; washing my hands prior to each session; use of hand sanitizer upon request; wiping down surfaces with disinfecting wipes and/or wearing a protective medical mask and/or gloves.

I agree to cancel my services should I have within the previous 24 hours to 2 weeks personally exhibited or have been in contact with someone who has presented with illness including; cough, sneezing, fever, chest congestion or additional signs of potential spread of any virus or bacteria/disease. In addition, I will follow the recommendations of Reinbow Riding Center once I have notified them of these risks in regards to my future services during this pandemic.

Reinbow Riding Center will engage in regular cleaning and sanitizing of horse tack, grooming supplies and "office", doors, and frequently touched areas in-between clients and on a daily basis as recommended by the CDC and state regulations for the safety of clients, employees, volunteers and horses.

I am signing under my own free will and choice and agree to follow these and hold harmless all individuals associated with or through my services acquired from Reinbow Riding Center.

Client Name: _____Date: _____

Client Signature: _____

Parent/Guardian Name: _____Date: _____

Parent/Guardian Signature: _____