



Rainbow Riding Center

Located at 892 Tarbellville Road

Belmont, VT 05730

802-236-2483

email: programs@rainbowridingcenter.org

website: rainbowridingcenter.org

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

School Registration Packet

Rainbow Riding Center is offering riding lessons for School students. 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.

Rainbow 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 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

Because we are an outdoor facility we encourage sun screen and bug spray be applied before coming.

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 Rainbow Riding Center?

Signature: _____ Date: _____

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 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

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 Wheelchair: Yes No
 Assisted ambulation: 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: _____

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 name: _____ Relationship: _____

Preferred Ph: _____ Work Ph: _____

Emergency contact 2: _____ Relationship: _____

Preferred Ph: _____ Secondary 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)

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: _____

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.

I _____ **do** _____ **do not** wish to receive program information via email.

Signature: _____ Date: _____

PARENT INPUT FORM

Your child will be participating in the Therapeutic Riding program at Rainbow 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?

SCHOOL PROVIDER INPUT FORM

The following student, _____, will be participating in the Therapeutic Riding program at Rainbow 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 Health and Safety Guidelines

802-236-2483

Reinbow Riding Center takes precautions to keep all participants healthy and safe. In that respect we would appreciate everyone, riders and accompanying adults, to also take normal precautions to help us accomplish this. Please make note of and call the above number to cancel your rider's lesson if they exhibit any of the following symptoms or symptoms of any other illnesses.

- Complaints of not feeling well
- Has a fever
- Persistent cough or wheezing
- Recent nausea or vomiting
- **Or has been exposed to someone with Covid or has tested positive for Covid within the past week.**

Please follow these guidelines to help us create and maintain a healthy and safe environment for everyone.

Directions to Reinbow Riding Center:

From the Rutland Area take Rte 103 south and watch for a right hand turn for Route 155 a little beyond Jiffy Mart. Stay on 155 to Belmont (3.8 miles). At the Belmont sign turn left onto Tarbellville Rd. Then turn left at the driveway for Reinbow Riding/Stonewall Farm (.2 miles) across from a grey house that's 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.**