# Capital Area Therapeutic Riding Association

**P.O. Box 339, Grantville, PA 17028-0339 (717) 298-7035 www.catra.net**

## RIDER REGISTRATION INSTRUCTIONS

*Please use this page as a checklist to make sure all parts of the Rider Registration are complete. The following steps must be completed prior to the rider's first lesson.*

1) **SET UP MEETING WITH CATRA'S RIDING INSTRUCTOR**

Call or text CATRA's riding instructor, Shirley Nolt, at 717-919-4587 to arrange for a meeting.

2) **COMPLETE THE ON-LINE SCHEDULING REQUEST**

The On-Line Scheduling Request form can be found on CATRA's website in the Rider Menu at the following link: https://www.catra.net/riders/new-riders/

In order for CATRA to accommodate all requests, please select several lesson days and times.

3) **RIDER REGISTRATION FORMS**

Complete and return the following forms:

- Rider Registration Information
- Liability Release, Photo Release, Authorization for Emergency Medical Treatment, and Consent/Non-Consent Plan
- Rider Medical History and Physician's Authorization (physician's signature required)
- Therapy Assessment (if working with a therapist)

Completed forms can be scanned and emailed to: RiderApplication@catra.net

or mail to:

Capital Area Therapeutic Riding Association
Attn: Cathy Gaster
PO Box 339
Grantville, PA 17028-0339

***Please note: The above Rider Registration forms must be completed and signed by a physician before the rider can get on a horse.***

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## RIDER REGISTRATION INFORMATION

**Rider's Name:** _____|_____|_____
First Last M.I.

**Age:** _____ **Date of Birth:** _____|_____|_____
Mo. Day Year

**Address:** _____
Street Address City State ZIP

**County:** _____

**School District:** _____ **School Attending:** _____

**Parent(s)/Legal Guardian(s):**

**Name:** _____ **Name:** _____

**Home Phone**: _____ **Home Phone**: _____

**Mobile Phone:** _____ **Mobile Phone:** _____

**Work Phone:** _____ **Work Phone:** _____

**Email:** _____ **Email:** _____

**Emergency Contact:**

**Name:** _____

**Relationship to Rider:** _____

**Home Phone:** _____

**Mobile Phone:** _____

**Work Phone:** _____

**Email:** _____

**Rider's Physician:**

**Name:** _____

**Address:** _____
Street Address City State ZIP

**Phone:** _____

**Rider's Physical Therapist:**

**Name:** _____

**Address:** _____
Street Address City State ZIP

**Phone:** _____

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## RIDER REGISTRATION INFORMATION (CONT'D)

## GENERAL INFORMATION

**Rider's Physical, Emotional or Mental Disability:** _____

**Date of Onset:** _____

**If physical disability, limbs affected:** _____

**Allergies: Yes ___ No ___ If yes, please list:** _____

**Current Medication(s) and Dosage:** _____

| Problem | Yes | No | If Yes, Describe: |
|---|---|---|---|
| Bladder | | | |
| Fainting | | | |
| Hearing | | | |
| Heart disease | | | |
| Heat exhaustion | | | |
| High blood pressure | | | |
| Respiratory disease | | | |
| Seizures – controlled? | | | Medications: |
| Shunt | | | |
| Skin (current & past) | | | |
| Subluxing or dislocating hips | | | |
| Visual | | | |

**Physical Aids (check if applicable):**

☐ Braces (type):_____
☐ Canes
☐ Crutches
☐ Walker
☐ Rolling Walker
☐ Wheelchair
☐ Eyeglasses
☐ Contact Lenses
☐ Hearing Aids
☐ Other (specify): _____

**Ambulatory Status (please check):**

☐ Uses wheelchair
☐ Walks with assistive devices
☐ Non-ambulatory
☐ Walks independently
☐ Needs assistance walking

**Please include any special problems (i.e., violent outbursts, emotional withdrawal, fears, any limitations, etc.):**

_____

_____

_____

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## LIABILITY RELEASE

_____ (rider's name) would like to participate in the Capital Area Therapeutic Riding Association program. I have discussed the risks and problems of horseback riding with my own/son's/daughter's/ward's doctor and acknowledge the risks and potential for risks in this activity. However, I believe that the possible benefits to myself/my son/my daughter/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 Capital Area Therapeutic Riding Association, its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward and immediate family may sustain while participating in the Capital Area Therapeutic Riding Association's program.

_____ _____ _____

Signature | Relationship (Self/Mother/Father/Legal Guardian) | Date

## PHOTO RELEASE (OPTIONAL)

I hereby consent to and authorize the use and reproduction by Capital Area Therapeutic Riding Association of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward to be used for promotional printed material, education activities, exhibitions or for any other use for the benefit of the association.

_____ _____

Signature (Client, Parent, or Guardian) | Date

## AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event 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 associate, I authorize CATRA to secure and retain medical treatment and transportation if needed.

**Rider's Name:** _____

**Address:** _____

STREET ADDRESS CITY STATE ZIP

**Emergency Contact Name(s):** _____ **Cell Phone:** _____ **Email:** _____

_____ **Cell Phone:** _____ **Email:** _____

**Physician's Name:** _____ **Phone:** _____ **Email:** _____

**Physician's Medical Facility:** _____

**Health Insurance Company:** _____ **Policy #:** _____

### 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 involved if the person listed below is unable to be reached.

Consent Signature: _____
Volunteer, Parent, or Guardian

Print Name: _____

Date: _____

Address: _____
STREET

_____
CITY STATE ZIP

### 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 services or while being on the property of the agent. In the event emergency treatment/aid is required, I wish the following procedures to take place: _____

_____

Non-Consent Signature: _____
Volunteer, Parent, or Guardian

Print Name: _____

Date: _____

Address: _____
STREET

_____
CITY STATE ZIP

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*TO BE COMPLETED BY A PHYSICIAN*

## RIDER MEDICAL HISTORY AND PHYSICIAN'S AUTHORIZATION

Rider's Name: _____ Sex: ___ Height: _____ Weight: _____

Age: _____ Date of Birth: _____|_____|_____
Mo. Day Year

Diagnosis: _____ Date of Onset: _____

Cause: _____

Limbs affected:_____

If spinal cord involvement, what vertebral level? _____

If Down's Syndrome, Atlanto-Axial subluxation? _____

Cervical x-ray for Atlanto-Axial subluxation? _____

Estimate of mental ability: _____

Check if applicable: ☐ Physically Handicapped ☐ Emotionally Disturbed ☐ Autism Spectrum Disorder
☐ Intellectual Disability ☐ Learning Disabled ☐ Developmentally Delayed

**MOBILITY STATUS:**

Can the rider ambulate? Yes ___ No ___

**Assistance:**
☐ Independent
☐ Minimal
☐ Moderate
☐ Maximal
☐ 1 Person Assist
☐ 2 Person Assist

**Physical Aids:**

☐ Braces (type): _____
☐ Canes
☐ Crutches
☐ Walker
☐ Rolling Walker
☐ Wheelchair
☐ Eyeglasses
☐ Contact Lenses
☐ Hearing Aids
☐ Other (specify): _____
☐ None

Does the rider use a wheelchair? Yes ___ No ___ Type of wheelchair: _____

Can the rider propel the wheelchair? _____

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*TO BE COMPLETED BY A PHYSICIAN*

## RIDER MEDICAL HISTORY AND PHYSICIAN'S AUTHORIZATION (CONT'D)

**Please indicate if the rider has any of the following secondary problems by checking yes or no. If yes, please include complete information pertaining to the problem:**

| Problem | Yes | No | If Yes, Describe or Indicate Medications |
|---|---|---|---|
| Visual | | | |
| Hearing | | | |
| Speech | | | |
| Cardiac | | | Pulse: Blood Pressure: |
| Circulatory: | | | |
| Peripheral Vascular Dis. | | | |
| Hemophilia | | | |
| Pulmonary | | | |
| Metabolic/G.I. G.U. | | | |
| Diabetes | | | |
| Bladder/Bowel Control | | | |
| Skin and Soft Tissue | | | |
| Pressure Sore | | | Healed? Yes ___ No ___ Location: |
| Surgery | | | Date(s) & Description: |
| Pain | | | |
| Medication | | | |
| Neurological | | | |
| Seizures | | | Controlled? Yes ___ No ___ Last Seizure: |
| Hydrocephalus | | | Shunt? Yes ___ No ___ |
| Sensory Loss | | | |
| Muscular | | | |
| Contractures | | | |
| Skeletal | | | |
| Subluxing Hips | | | |
| Dislocating Hips | | | |
| Spinal Laminectomy | | | |
| Scoliosis | | | Degree, Type, Last X-ray: |
| Kyphosis, Lordosis | | | Degree, Type: |
| Spondylosis | | | |
| Spondylolisthesis | | | |
| Osteoporosis | | | |
| Heterotrophic Ossification | | | |
| Arthrodesis | | | |
| Fractures | | | Healed? Yes ___ No ___ Location: |
| Allergies or Special Precautions | | | |

**Please describe any other additional information that might help us to work with this rider. If additional space is needed, please attach as a separate document. Thank you for your time.**

_____

_____

Physician's Signature: _____ Date: _____

Physician's Name (please print): _____

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## THERAPY ASSESSMENT

If you are currently working with one of the professionals listed below, please ask them to complete this form and return it to CATRA:

- Physical Therapist
- Occupational Therapist
- Speech Therapist
- Behavioral Therapist
- Other

The completed form can be scanned and emailed to: rider_application@catra.net

or mail to:

Capital Area Therapeutic Riding Association
Attn: Cathy Gaster
PO Box 339
Grantville, PA 17028-0339

Rider's Name: _____

Parent/Legal Guardian's Name: _____

Home Phone: _____

Cell Phone: _____ May CATRA text this number? Yes __ No __

Recommended Frequency for Therapeutic Horseback Riding:

1 time per week ___
2 times per week ___
3 times per week ___
4 times per week ___
5 times per week ___

Precautions:

_____

_____

_____

Therapist's Signature: _____ Date: _____

Therapist's Name (please print): _____

Address: _____

Phone: _____