Freedom Hills Therapeutic Riding Program, Inc.
P.O. Box 222,
Port Deposit, Maryland 21904-0222
(410) 378-3817
www.freedomhills.org

Dear Riders, Parents and Caregivers,

Thank you for your interest in the Freedom Hills Therapeutic Riding Program. Freedom Hills has been in operation since 1982. Our goal is to make riding therapy/lessons enjoyable and meaningful to all our riders while providing a safe and comfortable environment.

Individual lessons are currently $50.00 per hour and group lessons are $25.00 per hour and limited to 5 riders to assure maximum benefit to each rider. We ask that lesson payments for the entire month be made the first week of each month and every effort is made to attend the scheduled lessons. In the event of a cancellation, a 24 hour advanced notice is required at which time we will do our best to reschedule your lesson; should we not receive the notice or if the cancellation is other than medically related or an emergency, the lesson will be forfeited. Financial assistance is available on request for subsidized lessons.

Sidewalkers and a Headwalker are provided for those riders needing extra assistance. Parents and caregivers, please come prepared to assist your rider if necessary. Volunteer forms are enclosed; please fill them in completely.

While at the farm, appropriate footwear must be worn at all times by riders, volunteers and visitors; no open toes please! Riders are required to wear long pants, closed toed, hard sole shoes with a heel and a fitted helmet. For those with out a helmet, we have a variety of sizes on hand that may be borrowed during lesson time, but you are encouraged to bring your own. Helmets must be ASTM/SEI approved.

Freedom Hills participates in horse shows that offer our challenged riders a chance to compete. An annual show is held at Rolling Hills Ranch the end of October. Each rider is encouraged to participate. Riders are also encouraged to participate spring and fall in the shows held at Thorncroft in Malvern, Pennsylvania and in the summertime Maryland State Special Olympics and Les Autre Games which are held at the Prince George Equestrian Center.

A variety of fund-raisers are held throughout the year to help keep our riding fees low. Our biggest fund-raiser is an annual auction held in February or early March. Riders, parents, family and friends and other volunteers are encouraged to assist with these fund-raisers.

Please contact us if you have any questions. Upon completing the medical and rider's forms, please call to schedule your lessons. We look forward to riding with you!

Sincerely,

Renée

Renée Sherrard-Luther
Program Director

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Income Information

Please check one of the following:

□ We are requesting scholarship help and feel we can contribute $ ___________/month

□ We are not requesting scholarship help (but please see bottom section).

If scholarship help is requested, then this section must be filled out and proof of income **must** include copies of the following:

- **3** most recent (consecutive) pay stubs from your current employer or page 1 and schedule C of you most recent tax return if self-employed..
- Statement of child support, either outgoing or incoming (if applicable).
- Social Security, unemployment or disability papers (if applicable).

Scholarships are granted on a monthly basis. You will be expected to attend the lessons you have signed up for and to meet the contribution goal established above. While we understand that life events occur that prevent perfect attendance, you must understand that the lesson space is being held for you. If you do not attend during the period you have signed up for, then no one else will be able to use that time either.

Even if scholarship help is not requested, we would like to collect the following income and number of dependents information. If scholarship help is not requested, then proof of income should not be provided. Personal income information is strictly confidential and its use is restricted. Only necessary members of our administrative staff see specific family income (by name). Personal information is not released to any outside agency or group; family income is not used to target specific people for requests for contributions or other aid; all clients receive the same quality of care, regardless of family income. Income information for all families (without names) is used in three ways: In planning our budget, in requests for charitable contributions from outside agencies and assessing if we are fulfilling our mission of serving all segments of the community.

Please circle the box that applies in the following table. If your family has more than eight members, circle the appropriate income box for eight members and note how many family members there are in the comments section below:

Number of Persons In Family							
1	***2***	***3***	***4***	***5***	***6***	***7***	***8***
Income Range – Circle One Box							
<$15,150	<$17,300	<$19,500	<$21,650	<$23,400	<$25,100	<$26,850	<$28,600
$15,150- $25,250	$17,300 - $28,850	$19,500 - $32,450	$21,650 - $36,050	$23,400 - $38,950	$25,100 - $41,800	$26,850 - $44,700	$28,600 - $47,600
$25,251 - $40,400	$28,851 - $46,150	$32,451 - $51,950	$36,050 - $57,700	$38,951 - $62,300	$41,801 - $66,950	$44,701 - $71,550	$47,601 - $76,150
>$40,400	>$46,150	>$51,950	>$57,700	>$62,300	>$66,950	>$71,550	>$76,150

If requesting scholarship help, and any special circumstances apply such as extensive medical bills or special nursing care, multiple family members in the program, etc, please describe below:

____

____

____

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Rider's Registration and Release Form

Name: ____ Date of Birth: _____________ Age: _________
Address: ____
City/State: ____ Zip: ______________
Email: ____
Phone: Home: __________________ Work: ___________________ Mobile: _______________________

Parents or Guardians: Name: ____
Address: ____
City/State: ____ Zip: ______________
Email: ____
Phone: Home: __________________ Work: ___________________ Mobile: _______________________

Emergency Contact: Name/Relationship: ____
Address: ____
City/State: ____ Zip: ______________
Email: ____
Phone: Home: __________________ Work: ___________________ Mobile: _______________________

Comments: ____
____
____

Liability Release

_____________________________________(Client's Name) would like to participate in the Freedom Hills Therapeutic Riding Program, Inc. I acknowledge the risks and potential for risks of horseback riding. However, I feel 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 an assigns, executors or administrators, waive and release forever all claims for damages against Freedom Hills Therapeutic Riding Program, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injures and/or losses I/my son/my daughter/my ward may sustain while participating in Freedom Hills Therapeutic Riding Program, Inc.

Consent Signature: ____ Date: ________________
Client, Parent or Guardian

Photo Release

I hereby consent to and authorize the use and reproduction by Freedom Hills Therapeutic Riding Program, Inc. of any and all photographs and any other audiovisual/digital materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Consent Signature: ____ Date: ________________
Client, Parent or Guardian

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Rider's Authorization for Emergency Medical Treatment Form

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 this agency, I authorize Freedom Hills Therapeutic Riding Program, Inc. 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.

Client Name: ______________________ Date of Birth: __________ Age: ________

Address: ____

City/State: __________________________________ Zip: __________

Email: ____

Phone: Home: ______________ Work: ______________ Mobile: ________________

In the event I cannot be reached:

Contact: ____________________________ Phone: _______________

Contact: ____________________________ Phone: _______________

Physician's Name: ________________________

Preferred Medical Facility: ______________________________________

Health Insurance Co.: ______________________________________

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 invoked if the person below is unable to be reached.

Consent Signature: ______________________________ Date: ___________
Client, Parent or Guardian

Print Name: ______________________________ Phone: ___________

Address: ____

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 agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

____

____

Non-Consent Signature: ______________________________ Date: ___________
Client, Parent or Guardian

Print Name: ______________________________ Phone: ___________

Address: ____

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM

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Rider's Medical History and Physician's Statement
to be completed annually

Client Name: ______________________________ Date of Birth: __________ Age: ________

Address: ____

City/State: ____ Zip: __________

Diagnosis: ______________________________ Date of Onset: ____________________

Tetnus Shot: □ Yes □ No Date: ___________ Height: __________ Weight: _________

Seizure Type: ______________ Controlled: __________ Date of last seizure: ___________

Medications: ____

** For Persons with Down Syndrome:
- □ Negative Cervical X-ray for Atlantoaxial Instability. X-ray Date: ___________
- □ Negative for clinical symptoms of Atlantoaxial Instability.

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	**Yes**	**No**	**Comments**
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility:
- Independent Ambulation: □ Yes □ No
- Crutches: □ Yes □ No
- Braces: □ Yes □ No
- Wheelchair: □ Yes □ No

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Please indicate any special precautions:

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

Physician's Name (please print): ____

Physician's Signature: ____ Date: __________

Address:: ____

Phone: ____________________

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