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

Dear Participant, Parents and Caregivers,

Thank you for your interest in the Freedom Hills Therapeutic Riding Program. Freedom Hills has been in operation since 1982. We are a member of the Professional Association of Therapeutic Horsemanship International (PATH) Our goal is to make equine therapy/lessons enjoyable and meaningful to all our participants while providing a safe and comfortable environment.

Individual lessons are $60.00, semi privates are $50.00, group lessons are $35.00 and are limited to 5 participants to assure maximum benefit to each individual. We ask that lesson payments for the entire month are made the first week of each month and every effort is made to attend the scheduled lesson. A 24 hour advanced notice is required in the event of a cancellation at which time we will do or 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.

We do our best to provide Sidewalkers and a Headwalker for those riders needing extra assistance, however that is not always possible. 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 without 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. All 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 are held at the Prince George Equestrian Center.

A variety of fundraisers are held throughout the year to help keep our participant fees low. Our biggest fundraiser is an annual auction in the winter. Participants, parents, family, friends and other volunteers are encouraged to assist with these fundraisers.

Please contact us if you have any questions. Upon completing the medical and participant forms please call to schedule your lessons. We look forward to working with you!

Sincerely,

Renée

Renée Dixon
Executive Director

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Participant's Registration and Release Form Date_____

Client's Name: _____ Date of Birth: _____ Age: _____

Address: _____ City/State:_____ Zip:_____

Email: _____ Home Phone: _____

Work Phone: _____ Mobile Phone: _____

Parents, Guardian or Caregiver _____

Address: _____ Email: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Emergency Contact: Name/Relationship: _____

Emergency: Home Phone: _____ Work Phone _____ Mobile Phone _____

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 equine activities. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I am also aware of the risks of contracting a communicable disease while receiving services with Freedom Hills TRP. 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 and Rolling Hills Ranch LLC and its owners for any and all injures and/or losses I/my son/ my daughter/my ward may sustain while participating in the Freedom Hills Therapeutic Riding Program, Inc.

Date:_____ Consent Signature: _____
Client, Parent, Guardian or Caregiver

Date:_____ Non Consent Signature: _____
Client, Parent, Guardian or Caregiver

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.

Date:_____ Consent Signature: _____
Client, Parent, Guardian or Caregiver

Date:_____ Non Consent Signature: _____
Client, Parent, Guardian or Caregiver

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Participant'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's Name: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

In the event of an emergency: 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 "lifesaving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Date: _____ Consent Signature: _____
Client, Parent, Caregiver 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:

_____

_____

Date: _____ Consent Signature: _____
Client, Parent, Caregiver or Guardian

Print Name: _____ Phone: _____

Address: _____

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED

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Participant's Medical History and Health Provider's Statement

Client's Name: _____ Date of Birth: _____ Age: _____

Address: _____ City/State: _____ Zip: _____

Diagnosis: _____ Date of Onset: _____

** For Persons with Down Syndrome:

- ☐ Negative Cervical X-ray for Atlantoaxial Instability. X-ray Date: _____
- ☐ Positive Cervical X-ray for Atlantoaxial Instability. X-ray Date: _____
- ☐ Negative for clinical symptoms of Atlantoaxial Instability. X-ray Date: _____
- ☐ Positive for clinical symptoms of Atlantoaxial Instability. X-ray Date: _____

Tetanus Shot: ☐ Yes ☐ No Date: _____ Height: _____ Weight: _____

Seizure Type: _____ Controlled: _____ Date of last seizure: _____
Medications: _____

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 Please indicate any special precautions: _____

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, Nurse, Counselor or Health Professional Name (please print) _____

Physician, Nurse, Counselor or Health Professional Signature: _____ Date: _____

Address: _____ Phone: _____