

Dreams of Courage

Therapeutic Riding Program

Application / Evaluation Form

Name:		Date of Birth:		Phone:	
Parent/Guardian:					
Address:					
E-Mail Address					
Diagnosis:					
School Program:					
Physician's Name:			Address:		Phone:
Specialist Physician's Name:		Address:		Phone:	
<p>Please Note: <i>Precautions and contraindications to therapeutic horseback riding do exist. Registration is based on a signed medical form and evaluation by Dreams of Courage.</i></p>					
<p>The following questions are designed to help us determine a student's functional level.</p>					
Height:		Weight*		*weight limit is 200 lb.	
Head Control: Is the applicant able to stabilize head/neck against a quick forward movement? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Sitting:	Independently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How Long?	
	With assistance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Mobility	Crawl?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stands?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Walks with assistance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Device?	
	Walks independently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Protective reactions:	Can protect against loss of balance?	Sitting?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Standing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Communications:	Verbal?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Sign Language?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type?		
Vision/Hearing:	Describe impairment, if any:				
Riding Experience:	<input type="checkbox"/> Yes <input type="checkbox"/> No	How long?			
SIGNED:					

Dreams of Courage

Therapeutic Riding Program

MEDICAL FORM

Name:		Date of Birth:		Sex:	
Parent/Guardian:					
Address:				Height:	Weight:
Diagnosis:				Date of Onset:	
<i>**FOR PERSONS WITH DOWN SYNDROME**</i>					
Cervical X-ray for Atlantoaxial Instability:		Positive:	Negative:		X-ray Date:
Current clinical exam on (date):		Reveals NO symptoms of Atlantoaxial Instability		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Comments:					
MEDICATIONS (Type, Purpose, Dose):					
SEIZURE TYPE:		Controlled:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Last Seizure	
Please indicate if the client has a history of the following secondary problems by checking yes or no. If YES, please include COMPLETE information, including, surgical history, pertaining to the problem.					
PROBLEM	YES	NO	IF YES, OR HISTORY OF, DESCRIBE		
Auditory Impairment					
Learning Disability					
Mental Impairment					
Psychological Impairment					
Speech Impairment					
Visual Impairment					Glasses/Contacts
Allergies					Type if Reaction
Cardiac					
Circulatory					
Gastrointestinal					
Gastrostomy					
Pulmonary					
Asthma /COPD					
Neurological					
Hydrocephalus / Shunt					
Balance Impairment					
Sensory Loss					

Hypertonicity			
Urological			
Incontinence			
Indwelling Catheter			
Muscular			
Contractures			
Skeletal			
Spinal Column Injury			
Subluxing or Dislocating Joints			
Laminectomy			
Spinal Fusion			
Scoliosis- Degree/Type/Brace Last X-ray			
Kyphosis/Lordosis Degree /Type			
Spondylolisthesis			
Osteoporosis			
Heterotrophic Ossification			
Fractures			
Location:			Healed?
Other:			

MOBILITY STATUS

Ambulatory?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Assistive Device?	<input type="checkbox"/> Cane	<input type="checkbox"/> Crutches	<input type="checkbox"/> Walker
Prosthetics / Orthotics :	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify:	
Please indicate special precautions:			

MEDICAL FORM - Continued

IN MY OPINION THE INDIVIDUAL NAMED ABOVE CAN PARTICIPATE IN SUPERVISED MOUNTED EQUESTRIAN ACTIVITIES. I HAVE REVIEWED THE LISTED PRECAUTIONS AND CONTRAINDICATIONS AND ANY DESCRIPTIVE MATERIALS ENCLOSED. THIS FORM IS VALID FOR A PERIOD OF ONE YEAR FROM THE DATE SIGNED.

Physician's Signature:	Date:
Due to our accreditation guidelines, we accept only signatures of MD's or DO's	
Physician's Name (Please Print)	
Physician's Address:	
Telephone Number:	

INFORMATION FOR PHYSICIANS Precautions & Contraindications to Therapeutic Riding

PRECAUTIONS	CONTRAINDICATIONS
Hip subluxation / dislocation	Osteogenesis Imperfecta
Scoliosis > 30	Atlantoaxial dislocation condition
Osteoporosis	Total hip arthroplasty
Hydrocephalus / Shunt	Spinal fusion
Seizure disorders	Spinal instability Spinal cord injury above T12

Dreams of Courage
Therapeutic Riding Program

EDUCATION EVALUATION

The parents of _____ have enrolled him/her in the Dreams of Courage therapeutic horseback riding program. Dreams of Courage strives to extend the social, emotional and educational development goals identified by parents and educators into the horsemanship experience.

Your cooperation is essential to the achievement of this rider. Please complete the requested information.

Parent/guardian authorization to release information:

Signature _____



TASK	GOAL /PLAN
Social interaction skills	
Self-concept / self esteem	
Decision-making skills	

TASK	GOAL /PLAN
Understanding Consequences of Personal actions	
Ability to follow Directions	
Listening skills	
Verbalization skills	
Other comments:	



Signature of Educator:	Date:
School:	Daytime Phone:

Please Return to:
Dreams of Courage
 North Wind Equestrian Center
 1768 Newt Green Road
 Cumming, Ga. 30040

Dreams of Courage
Therapeutic Riding Program

**PHYSICAL OR OCCUPATIONAL THERAPY
 EVALUATION FORM**

The individual, or parent of _____ has enrolled in the Dreams of Courage therapeutic horseback riding program. Dreams of Courage strives to extend the physical/occupational therapy goals of this individual into the horsemanship experience.

Your cooperation is essential to the achievements of this rider. Please complete the requested information.

Parent / guardian / client authorization to release information:

Signature: _____



Evaluation Date:	
Diagnosis:	Description:
Surgeries performed (with dates):	
Other pertinent Medical history:	
Muscle strength:	Gross:
Special weakness:	
Joint ROM:	Gross:
Specific limitations:	
Muscle Tone:	
Balance:	Sitting:
Standing:	
Coordination:	Gross motor:
Fine Motor:	

Reflex activity	Developmental:		
Pain:	Character:	Location:	
	Caused by:	Relieved by:	
Sensory impairment:			
Perceptual problems:			
Communication difficulties:			
Skin condition:			
Functional abilities	Mobility:		
Transfers:			
ADL skills:			
Additional comments:			



Problem List	Goals / Plan
1.	
2.	
3.	
4.	
5.	
6.	



Signature:	Date:
Daytime phone:	
Please return to:	<p align="center"><i>Dreams of Courage</i> North Wind Equestrian Center 1768 Newt Green Road Cumming, Ga. 30040</p>

Dreams of Courage
Therapeutic Riding Program

Parent Survey

Name:	Date:
Dear Dreams of Courage Parents: Please fill out the following questionnaire to help us better serve your child.	
What specific skills would you like to see addressed during this session? (i.e.: balance, Communication, etc.)	
What specific behavior of your child would you like to see encouraged? Discouraged?	
What are important interests / activities for your child at home and at school?	
Does your child have specific fears and/or problems of which our volunteers should be aware?	
As riding independence is encouraged, some risk is inevitable. How do you feel about this?	
Please share any other information you feel would help us better serve your child.	