**Dream Walkers Equine Therapy Center**

**Client Application Part 1**

Applicant Name: ­­­­**Therapy Center\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Gender: [ ] Male [ ] Female

Height: \_\_\_\_\_\_\_\_\_\_Weight: \_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity (not required): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:

Phone (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Other):

Address:

City, State, Zip:

Name of Current School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referral Source:

Parent/legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:

Number of People in Household: \_\_\_\_\_\_\_\_\_\_\_\_\_

**SCHEDULING INFORMATION**

Normal riding times are Tuesday – Friday, 6:00 p.m. – 8:00 p.m.; Saturday, 9:00 a.m. – 12:00 p.m.

Each student rides 1-2 times per week. Each lesson lasts from 30 minutes – 1 hour.

For scheduling purposes, please fill in ALL the times your child will be available to ride each day.

[ ]  Tuesday:

[ ] Wednesday:

[ ]  Thursday:

[ ] Friday:

[ ] Saturday:

**HEALTH HISTORY:**

Please indicate current/past problems in the following areas (Please include triggers, if any):

Vision:

Hearing:

Sensation:

Communication:

Heart:

Breathing:

Digestion:

Elimination:

Circulation:

Emotional:

Circulation:

Emotional:

Behavioral:

Pain:

Bone/Joint:

Muscular:

Thinking/Cognitive:

Allergies:

Current medications of applicant, including over-the-counter medications:

Please describe applicant’s FUNCTIONAL abilities and difficulties, such as: mobility skills (transfers, walking, wheelchair use, driving/bus riding):

\*\*Please describe assistance required or equipment needed:

Please describe applicant’s SOCIAL abilities and difficulties, such as: work/school (grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.):

\*\*Please describe assistance required or equipment needed:

**MEDICAL HISTORY AND PHYSICIAN’S STATEMENT** (To be completed by physician only)

Applicant Name: ­­­­Therapy Center\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: [ ] Male [ ] Female

Height: \_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Assisted Ambulation: [ ]  Yes [ ]  No

Wheelchair: [ ]  Yes [ ]  No Braces/Assistive Devices: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR THOSE WITH DOWN SYNDROME:**

AtlantoDens Interval X-Rays, Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neurologic Symptoms of AtlantoAxial Instability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE INDICATE CURRENT/PAST DIFFICULTIES IN SYSTEMS/AREAS; INCLUDE SURGERIES:

Auditory: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Visual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tactile Sensation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Speech: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiac: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circulatory: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Integumentary/Skin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immunity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pulmonary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neurologic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Muscular: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Balance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Orthopedic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Learning Disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cognitive: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emotional: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 (eg. PT, OT, ST, Psychologist, etc.) in the implementations of an effective equestrian program.

Name/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License/UPIN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN’S PRESCRIPTION** (To be completed by physician only)

Dear Physician:

Your patient, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, is interested in participating in supervised equestrian activities. In order to safely provide this service, our operating center requests that you complete/update the Medical History and Physician’s Statement. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree:

**Orthopedic**

Atlantoaxial Instability, incl neurologic symptoms

Coxa Arthrosis

Cranial Deficits

Heterotopic Ossification/Myositis Ossifications

Joint Subluxation Dislocation

Osteoporosis

Pathologic Fractures

Spinal Fusion/Fixation

Spinal Instability/Abnormalities

**Neurologic**

Hydrocephalus/Shunt

Seizure

Spina Bifida/Chiari II Malformation/Tethered Cord

Hydromyelia

**Other**

Indwelling Catheters

Medications (i.e. photosensitivity)

Skin Breakdown

**Medical/Psychological**

Allergies

Animal Abuse

Physical/Sexual Emotional Abuse

Blood Pressure Control

Dangerous to self or others

Exacerbations of medical conditions

Fire Settings

Heart Conditions

Hemophilia

Medical Instability

Migraines

PVD

Respiratory Compromise

Recent Surgeries

Substance Abuse

Thought Control Disorder

Weight Control Disorder

*Thank you very much for your assistance. If you have any questions or concerns regarding this patient’s participation in therapeutic equine activities, please feel free to contact the operating center at the address and phone indicated below.*

**Physician’s Prescription**

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prescription for Therapeutic Horseback Riding**

Prescription, where appropriate for evaluation and treatment by a Physical, Occupational, and/or Speech Therapist in conjunction with Dream Walkers Equine Therapy Center.

Recommended Frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Precautions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DREAM WALKERS EQUINE THERAPY CENTER**

**SERVICES OFFERED**

**Therapeutic Riding:** for individuals with physical and/or cognitive disabilities that interfere with the tasks of daily living**.** Riders are usually under the care of a physical therapist, occupational therapist, mental health therapist, neurologist and/or other specialists on a regular basis. These riders often need assistance with ambulation and require close guidance to participate in riding activities.

**Adaptive Riding:** for individuals who have special needs that may require some adaptations but are mostly independent or working toward achieving independence. These students may have mild cognitive, emotional or physical issues, and are mostly ambulatory (may need minor assistance). They have the cognitive ability to follow the directions of their riding instructor with minimal assistance

INITIAL ASSESSMENT: $50.00

LESSON FEES: All fees are due two weeks before the start of the session to ensure the scheduled lesson time.

INDIVIDUAL LESSON: $30, or $350 for 12 riding sessions (recommended)

**Authorization for Emergency Medical Treatment**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:

Phone:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #:

Allergies to Medications:

Current Medications:

**Emergency Contacts:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Center, I authorize Dream Walkers Equine Therapy Center to:

1. Secure and retain medical treatment and transportation, if needed.
2. Release volunteer records upon request to the authorized individual or agency involved in the medical emergency treatment.

**(Please sign the Consent Plan or the Non-Consent Plan on next page)**

**Authorization for Emergency Medical Treatment**

**Consent Plan**

I **DO** give authorization that may include x-ray, surgery, hospitalization, medication, and any treatment procedure deemed “life saving” by the physician. This provision will only be invoked if the emergency contact person(s) above is not able to be reached.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If under 18 years of age, parent/guardian signature required below.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If under 18 years of age, parent/guardian signature required below.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Photo and Video Consent**

I, ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, consent\_\_\_\_\_\_ or do not consent \_\_\_\_\_\_ to authorize the use and reproduction by Dream Walkers Equine Therapy Center of any and all photographs, video/audio materials taken of me for the purpose of ongoing studies, educational activities, exhibitions, promotional materials or for any other use for the benefit of the program.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If under 18 years of age, parent/guardian signature required below.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dream Walkers Equine Therapy Center**

**RELEASE OF LIABILITY**

This Release of Liability is made and entered into on this date \_\_\_\_\_\_\_\_\_\_\_\_ and for thereafter between Pauline A. Garcia (Executive Director) and Dream Walkers Equine Therapy Center and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (The Participant); and, if Participant is a minor, their Parent or Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. In return for use, today and on future dates, of the property, facility and services of the Executive Director, the Participant, his heirs, assigns and legal representatives, hereby expressly agree to the following:

1. It is the responsibility of the Participant to carry full and complete insurance coverage on his horse if he owns or leases one, personal property, and herself.
2. Participant agrees to assume Any and All Risks Involved in or Arising from Participant’s Use of or Presence Upon Dream Walkers Equine Therapy Center, and the Executive Director’s Property and Facility including without limitation the risk of death, bodily injury, property damage, all kicks, bites, collisions with vehicles, horses, or stationary objects, fire or explosion, the unavailability of emergency care, or the negligence or deliberate act of another person.
3. Participant agrees to hold Dream Walkers Equine Therapy Center , the Executive Director and all its successors, assigns, subsidiaries, franchises, affiliates, officers, directors, employees, and agents completely harmless and not liable, and releases them from all liability whatsoever, and Agrees Not to Sue them on account of, or in connection with any claims, causes of action, injuries, damages, costs, or expenses arising out of the Participant’s use of or presence upon Dream Walkers Equine Therapy Center, and the Executive Director’s property and facility, including without limitation, those based on death, bodily injury, or property damage, including consequential damages.
4. Participant agrees to waive the protection afforded by any statute or law in any jurisdiction whose purpose, substance and/or effect is to provide that a general release shall not extend to claims, material or otherwise, which the person giving the release does not know or suspect to exist at the time of executing this release.
5. Participant agrees to indemnify and defend Dream Walkers Equine Therapy Center and the Executive Director against, and hold it harmless from any and all claims, causes of action, damages judgments, costs or expenses, including attorney’s fees, which in any way arise from the Participant’s use of or presence upon Dream Walkers Equine Therapy Center and the Executive Director’s property or facility.
6. Participant agrees to abide by all of Dream Walkers Equine Therapy Center’s and the Executive Director’s safety rules and Regulations.
7. This contract is non-assignable and non-transferrable, and is made and entered into in the State of Texas, and shall be enforced and interpreted under the laws of this State. Should any be in conflict with State Law, then that clause is null and void. When Dream Walkers Equine Therapy Center, the Executive Director and Participant, or Participant’s Parent or Legal Guardian if Participant is a minor, sign this contract, it will then be binding on both parties, subject to the above terms and conditions.
8. Warning: Under Texas Law (Chapter 87 Civil Practice and Remedies code) an Equine Professional is not liable for an injury to and/or the death of a participant in equine activities resulting from the inherent risks of equine activities. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If under 18 years of age, parent/guardian signature required below.**

 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RULES OF PARTICIPATION**

Dream Walkers Equine Therapy Center (DWETC) is a member of the Professional Association of Therapeutic Horsemanship International (PATH INTL) and, as such, strictly follows their standards and guidelines. The following rules are created for your utmost safety and comfort as we greatly value your participation and support. We want

DWETC to be a safe, caring, and fun environment for all who participate.

1. DWETC is a working horse farm. We have program horses as well as privately owned horses and dogs. **PLEASE LEAVE YOUR DOGS AT HOME.**

2. **Young children are NOT ALLOWED to chase or tease any animal. ALL children are to be SUPERVISED at all times while on the premises.**

3. Every visitor is required to read and sign a Liability of Release for Dream Walkers Equine Therapy Center.

4. Please remain outside the arena during the riding session.

5. During a riding session, please keep conversations to a minimum as it is difficult for side-walkers and horse leaders as well as our riders to hear the instructor over background noise and chatter. Also**, *please do not shout out directions or distract the riders in any way!*** It is important for everyone’s safety that during a lesson, the attention of the participants is focused on the riding instructor. Disruptive behavior will not be tolerated and persons causing distractions will be asked to leave and escorted from the premises, if necessary. In the case of an emergency, attention should be directed to the riding instructor in charge.

6. Running and sudden movements can startle a horse. By nature, all horses’ primary impulse is to flee perceived danger, which makes them potentially dangerous. Please WALK at all times while on the premises. Please do not bring toys such as balls, bats, balloons, Frisbees or any other equipment onto the property. **Do not use flash photography without the express consent of the riding instructor**. Some horses become very alarmed with flashes and could bolt. Also, please do not bring radios or electronic equipment that makes noise. Photography and videotaping must be approved by Dream Walkers prior to the riding session.

7. **DWETC is a tobacco, drug and alcohol free environment**. **Smoking is strictly prohibited**. Hay, stall bedding and stables are extremely flammable. Anyone showing signs of intoxication or substance impairments will be asked to leave the premises immediately. Second offenses will result in permanently being banned access to DWETC.

8. We are committed to creating and maintaining a supportive, compassionate and caring environment for all who come to participate at our center. Hostile or threatening behavior of any kind will not be tolerated. This includes physical or verbal abuse, insults, ridicule, harassment or discrimination of any kind. ***Any exhibition of violence or threatening behavior by any individual against another person, animal or property will be escorted from the premises and not permitted to return.*** If harm is incurred by any person, animal or to the property, the incident will be reported immediately to local law enforcement officials. If you observe anyone violating these regulations, or if you are victim to any kind of inappropriate behavior, please do not hesitate to notify the riding instructor in charge immediately.

9. **In the case of an emergency, please stay calm and listen for instructions from the riding instructor in charge.** Given the unpredictable nature of horses, it is best you don’t move from your position unless it is necessary to move out of harm’s way.

10. Parents or guardians who bring a rider to a lesson are required to remain for the duration of the lesson. This is essential for the rider’s safety. The unexpected can and does happen and we need you to be available at all times during the lesson, should the instructor need your assistance.

**And, finally, while at DWETC we want you to have a safe and enjoyable experience – we are glad to have you here!**

**DIRECTIONS TO DREAM WALKERS EQUINE THERAPY CENTER**

From Uvalde:

Go north on Hwy 83 approximately 10 miles. Turn right onto FM 2690. Go approximately 1.5 miles and turn right on Hwy 101. Center will be ¼ of a mile on the left.

From Leakey:

Go south on Hwy 83 approximately 30 miles. Turn left on to FM 2690. Go approximately 1.5 miles and turn right on Hwy 101. Center will be ¼ of a mile on the left.

From ConCan:

Go southeast on Hwy 127 approximately 10-12 miles. Turn right onto FM 2690. Go approximately 10 miles and turn left onto Hwy 101. Center will be ¼ of a mile on the left.

**Dream Walkers Equine Therapy Center**

Pauline A. Garcia, Founder/Executive Director

1740 FM 2690

Uvalde, TX 78801

(830) 279-7758

info@dwetc.org

[www.dwetc.org](http://www.dwetc.org)