



We are pleased that you have expressed interest in our program.

SpiritHorse provides therapeutic horseback riding services to children and adults with both physical and emotional disabilities. We are part of a group that currently serves more children than any center in the world.

SpiritHorse has developed a research-based program of equine-assisted healthcare, which is has a different goal than that of recreational therapy. It includes, for example, 178 specific steps provided in a one-on-one setting for intervening with its children who have been diagnosed with autism spectrum disorder.

SpiritHorse provides the only child development services some of our children will ever receive. We teach many things taught in the school systems to typical kids. For example, we teach those diagnosed with autism how to focus and stay on a specific task through having leading, grooming, and tacking up as part of the lesson. We have seen miraculous breakthroughs with our children when they start performing these tasks.

The program has reached an agreement with the University of North Texas and The Autism Treatment Center to study the results of biofeedback therapy coupled with our equine healthcare for children with autism.

Championing the use of retired show and rescue horses and ponies is also a major goal at SpiritHorse. These horses are ideal for this type of work because they have had years of professional training and show experience. These schoolmasters are the safest mounts for children with disabilities. Since most of the work is walking and our children cannot ride for very long, it's not really much more work than walking around the pastures where they live 24/7. Our horses and ponies love their work. Bandit is over thirty years old and waits by the pasture gate each morning to go to work.

Please complete the attached application thoroughly. Once all sections are complete, please return either via email to [Spirithorsewec@gmail.com](mailto:Spirithorsewec@gmail.com) or by mail to: Spirit Horse at Windermere Equestrian Center

PO Box 784852  
Winter Garden, FL 34778

Should you have any questions, please feel free to contact Shannon Crisante (321) 239-4570.

We look forward to working with you.

**OFFICE USE ONLY:** Date Received: \_\_\_\_\_

Entered by \_\_\_\_\_ Scanned

# Therapeutic Riding Application

*Spirit Horse at Windermere Equestrian Center*

*Updated Jan, 2018*

## **I. PERSONAL INFORMATION** *(Please print legibly)*

Applicant Name: \_\_\_\_\_  Female  Male

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

Parent/Legal Guardian: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ May we send text messages on this number?  
 No  Yes

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

*Providing my email address allows Spirit Horse at windermere equestrian center to send me program news, updates, information, and etc. This email shall remain the property of Spirit Horse and will not be sold or given to any third parties.*

**\*Which is the best number to use for lesson & scheduling communications?** \_\_\_\_\_

Name of current school: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Employer: \_\_\_\_\_ Are you a Disney cast member?  No  Yes

**\*\*Every applicant must have all pages completed along with a doctor signed diagnosis (pages 10 - 12)\*\***

## II. REGISTRATION

Our one-time registration fee is \$45 per student. This fee is due with submission of your application.

## III. NEW RIDER EVALUATION

There is a non-refundable fee of \$45 required at the time of your new rider evaluation. These are scheduled after receipt of application and completed forms. A new rider evaluation is a very important part of our program. It allows our instructors to determine a rider's base skill level, abilities, appropriate horse, volunteer needs and the most suitable lessons available.

## IV. LESSON COST & PAYMENT

Our therapy riding lessons are approximately 60-minute lessons and cost \$45.00 each. Lesson payments are due at the time of lesson. Convenient pre-payment options are available. Payment can be made by check payable to: *Spirit Horse at Windermere Equestrian Center*.

## V. SCHEDULING INFORMATION

Our therapy program runs on a 12-week cycle. Each student rides once per week for 12 weeks. After 12 weeks, you will have the option to re-up pending availability & need. Our goal is to help as many people as possible. To do so, we will take wait list names for interested applicants. New riders will be given the option to complete a 12-week cycle when space becomes available.

For scheduling purposes, please list your availability for lessons. Please list as many availability options as possible to increase your scheduling options.

Monday: \_\_\_\_\_

Friday: \_\_\_\_\_

Tuesday: \_\_\_\_\_

Saturday: \_\_\_\_\_

Wednesday: \_\_\_\_\_

Sunday: \_\_\_\_\_

Thursday: \_\_\_\_\_

## VI. LESSON INFORMATION

- Proper attire must be worn for all riding lessons including appropriate foot wear.
- Lesson times are scheduled in advance.
- It is important that the rider arrive 10 minutes prior to lesson time. This will allow adequate time to account for any last minute adjustments.
- If rider is late, the time for ending the lesson end time will remain as scheduled and lesson time will be reduced. Please be respectful of those lessons that are scheduled after you.
- If rider is unable to attend a scheduled lesson or must cancel, the instructor shall be notified at least 24 hours in advance. If this advance notice is not given/received, we reserve the right to charge for this lesson. No call/no shows will result in a charge for the lessons as well.
- Occasionally, lessons may need to be cancelled for weather reasons, horse health issues or any

unforeseen circumstance, every effort will be made to reschedule your lesson to a convenient time.

- To promote a greater connection between horse and rider, lesson time may include grooming, tacking, untacking, post ride grooming, bathing (when necessary) in addition to riding time.
- While a riding lesson is in progress all parents, family members, and guests must remain outside of the arena or riding area.
- Horses may not be handled in or out of the stalls without staff supervision, unless approved.

## V. 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: \_\_\_\_\_

Behavioral: \_\_\_\_\_

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

Bone/Joint: \_\_\_\_\_

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

Thinking/Cognitive: \_\_\_\_\_

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

Current Medications of Applicant (over-the counter included):

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:

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## VI. ADDITIONAL INFORMATION

Goals (reason for applying; what would you like to see accomplished): \_\_\_\_\_

Please tell us about the applicant. (Likes: Favorite food, hobbies, pets, home life, siblings. Dislikes: pets, sounds, etc.): \_\_\_\_\_

What types of things work best for the applicant in terms of rewards and motivation? \_\_\_\_\_

How does the applicant best communicate with others?

Spoken Language

Sign Language

Written Language

ASL

E/E

Communication device

Combination of the above (please describe): \_\_\_\_\_

Does the applicant use:

Echolalia (repeating words without regard for meaning)

Stemming (rocking, spinning, hand flapping)

Self Regulatory Behavior (Please describe how the applicant uses this self soothing behavior):

Do changes in the applicant's environment affect their behavior?

Never    Sometimes    Frequently

## VII. AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

*Specific information is requested in the event the participant is unable to present this information on their own behalf.*

Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Applicant's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Medical Facility: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Current Medications: \_\_\_\_\_

### **Emergency Contacts:**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ 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 agency, I authorize Spirit at Windermere Equestrian Center, Inc. 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.

**VIII. 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 unable to be reached.

Physician's Name: \_\_\_\_\_ Physician's Number: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Current medications: \_\_\_\_\_

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

**IX. 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: \_\_\_\_\_

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

**X. PHOTO & VIDEO CONSENT**

I \_\_\_\_\_ give my consent \_\_\_\_\_ **do not** consent to authorize the use and reproduction by Spirit Horse at Better Times Farm, Inc of any and all photographs, video/audio materials taken of the applicant for the on-going studies, educational activities, exhibitions, promotional materials or for any other use for the benefit of the program.

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



**LIABILITY WAIVER**

*Updated September 8, 2013*

Participant's Name: \_\_\_\_\_

I/We understand that horseback riding and related activities are very dangerous and involve the risk of serious injury and/or death, and/or property damage, including injury and/or death to horses, spectators and others. Accordingly, I/We agree that any activity engaged in by me on the premises of Spirit Horse at Windermere Equestrian Center, Windermere Equestrian Center, or related to horses or horseback riding, if on the premises, is done at my own risk. Accordingly, I/We release and agree to hold harmless Spirit Horse at Windermere Equestrian Center and Windermere Equestrian along with their owners and employees, and any and all persons or entities who are guarantors or indemnities of the above, all agents, employees, promoters, sponsors, other horse riders, horse owners, advertisers, sales persons, photographers, volunteers, (hereinafter called Releasees) from all liability for negligence or otherwise.

I/We assume full responsibilities for the risk of bodily injury, illness, death of myself/my son/my daughter/my ward and/or my/their horse(s) and any property damage due to the negligence of Releasees or otherwise while on the premises of Spirit Horse at Windermere Equestrian Center or Windermere Equestrian Center along with their owners and employees or heavily engaged in horseback riding related activities, and/or while training, riding, competing, officiating, observing, volunteering, teaching, boarding, working for, or for any purpose relating to horseback riding, eventing, or participating as rider or spectator in such activities.

I/We agree not to sue any Releasees, and I/We release and agree to indemnify for the Releasees from and for all liability for the undersigned, his/her person, representatives, assignees, heirs, and demands therefore on account of injury to his/her person or property, or death of the undersigned whether caused by the negligence of the Releasees or otherwise.

I/We agree that this release, waiver, and indemnity agreement is intended to be as broad and inclusive as is permitted by the law of this state where these activities are conducted, and if any part hereof is held invalid, it is agreed that the balance shall continue of full force and effect.

I/We have read and voluntarily signed the release and waiver of liability and indemnity agreement and further agree that no oral representations, statements, or inducements apart from the foregoing written agreements have been made nor shall be made except by a written and signed addendum.

**Warning, under Florida law, an equine activity sponsor or equine professional is not liable for an injury to or the death of, a participant in equine activities resulting from the inherent risks of equine activities.**

I have read this entire release and agree to its contents.

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

**PHYSICIAN'S PRESCRIPTION**

(To be filled out 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 & 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 - include 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

**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

**OTHER**

Indwelling Catheters  
Medications - i.e. photosensitivity  
Skin Breakdown

*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. Sincerely, Spirit Horse at Windermere Equestrian Center, Inc.*

**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 Spirit Horse at Windermere Equestrian Center, Inc.

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

Precautions: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_

*Spirit Horse at Windermere Equestrian Center, Inc, PO Box 784852 Winter Garden, FL 34778*  
[spirithorsewec@gmail.com](mailto:spirithorsewec@gmail.com) 407-468-7877

**MEDICAL HISTORY & PHYSICIAN'S STATEMENT**

(To be filled out by physician only)

Applicant Name: \_\_\_\_\_

Male 1 Female 1

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

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_ Past/

Prospective Surgeries: \_\_\_\_\_

Medications: \_\_\_\_\_

Seizure Type: \_\_\_\_\_ Controlled: 1 Yes 1 No Date of Last Seizure: \_\_\_\_\_ Shunt

Present: 1 Yes 1 No Date of Last Revision: \_\_\_\_\_

Special Precautions/Needs: \_\_\_\_\_

Mobility: Independent Ambulation: 1 Yes 1 No  
Wheelchair: 1 Yes 1 No

Assisted Ambulation: 1 Yes 1 No  
Braces/Assistive Devices: \_\_\_\_\_

For Those With Down Syndrome: Neurologic Symptoms of AtlantoAxial Instability: \_\_\_\_\_

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Other: \_\_\_\_\_

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, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

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

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