PO Box 1148, Bridgehampton, NY 11932
631-488-0142
www.ctreeny.org

Dear Potential Participant,

Thank you for your interest in CTREE!

Please complete all the forms and return them to our office as soon as possible.

The Participant Application Forms should be completed by the rider or rider's parent/guardian. This includes the following releases:

- The liability release ***must*** be signed and dated.
- The photography/video release/non-release *must* be signed and dated.

The 2 Page Physician Form ***must*** be submitted to your **doctor/therapist** for signature.

The Authorization for Emergency Medical Treatment ***must*** be completed, dated and signed in two places.

When we receive your completed paperwork, we will contact you to arrange for an evaluation session. This will be conducted as a private session by a NARHA certified instructor and trained volunteer aide(s) to handle the horse and assist the rider. The evaluation will also include a short tour of our barn.

Please be aware that there are certain precautions and contraindications associated with therapeutic riding. These are listed on the Health Care Provider Letter. Please be sure to read our Rider Eligibility Guidelines. If you have any questions, feel free to call us.

Once again, thanks for contacting CTREE! We look forward to meeting you soon!

Sincerely,

Karen

Karen T. Bocksel
Managing Director

For Office Use Only:
*Eval:*_____
*DB:*_____
*CC:*_____

Participant Application

Page 1
General Information

Name _____

DOB _____ Age _____ Height _____ Weight _____ Gender M ____ F ____

Address _____

Phone (home) _____ E-mail _____

Cell Phone _____ Preferred Method of Communication ____phone ____cell ____email

Employer/School _____ Phone _____

Address _____

Parent/Legal Guardian _____

Address (if different than above) _____

Phone(s) _____

Caregiver Name _____ Phone _____

Referral Source _____ Phone _____

How did you hear about our program? _____

Health History

Diagnosis _____ Date of Onset _____

Please indicate current of past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Cognitive			
Allergies			

Signature _____ Date _____

Participant Application, Page 2

MEDICATIONS (include prescription, over-the-counter; name, dose and frequency)

LIABILITY RELEASE

It is understood that, being aware of the risks and exposures to personal injury involved through equestrian activities, I hereby release Center for Therapeutic Riding of the East End (CTREE) and Twin Oaks Farm, LLC from all and every claim for damages which may occur to me or property in any connection with any lesson, clinic, practice, schooling or any work with horses on the grounds or away from the grounds of Twin Oaks Farm, 93 Merchants Path, Sagaponack, New York.

Signature _____ Date _____
(Client or parent/legal guardian)

PHOTOGRAPHY RELEASE

I hereby irrevocably consent _____ non-consent _____ to allow Center for Therapeutic Riding on the East End (Ctree) to use the photograph(s) and/or video(s) of me for any purpose, and in any manner, including without limitation to print media, social media, television, exhibition, publication, and any trade or advertising purpose, providing such uses are not made so as to constitute a direct endorsement by me of any product or service.

Signature _____ Date _____
(Client or parent/legal guardian)

PHYSICAL FUNCTION (i.e. Mobility skills such as transfers, walking, driving, bus riding, etc.)

PSYCHOLOGICAL FUNCTION (i.e. Work/school including grade completed, leisure interests, relationships, family structure, support systems, companion animals, fears/concerns, etc.)

GOALS (i.e. Why are you applying for participation? What would you like to accomplish?)

CTREE Rider Information

This information may be used by CTREE staff to assist in lesson planning for therapeutic riding.
Please complete the form to the best of your knowledge.

Name _____ Age _____ School _____

Please describe the rider's personality _____
_____
_____

List the rider's favorite activities _____

List any rider fears or dislikes (include any tactile, smell, hearing sensitivities) _____

Does the rider know/understand the following: *(explain below if needed)*

Educational/Cognitive	**Social**	**Language**
___Knows numbers	___Recognizes name	___Makes sounds/gestures
___Knows letters	___Knows word NO	___Says words
___Knows left and right	___Waves/says hello/bye	___Combines two or more words
___Knows prepositions	___Shares toys/items	___Speaks in complete sentences
___Describes feelings	___Understands rules	___Understands simple concepts
___Makes choices	___Appropriate touching	___Understands complex concepts
___Follows 1 step direction	___Interacts with peers	___Sounds out words
___Follows multi-step direction	___Appropriate conversation	___Recognizes sight words
___Good problem solving	___Makes eye contact	___Reads sentences

Rider communicates: _____verbally, _____with assistive device, _____ sign language, _____picture icons, _____ gestures, _____ sounds.

Check off the following physical skills that apply to the rider

___Stand on one foot	___Dresses self	___Opens doors/containers
___Hop/jump	___Rides a bike	___Uses utensils/tools
___Skip	___Plays sports	___Manipulates fasteners
___Weight bearing on hands	___Kick a ball	___Plays on swing
___Hold Object	___Catch a ball	___Writes legibly
___Release object		

Rider/Family Goals:

Signed _____ Relationship to Rider _____ Date _____

Participant Eligibility Guidelines

CTREE will make every effort to meet the needs of all riders who apply for therapeutic riding or equine assisted activities.

However, the nature of these activities includes limitations, precautions and occasionally contraindications. These are due to a variety of causes, most notably the following:

- Size and weight-carrying ability of the available horses
- Nature of a disability or condition that would make it unsafe for an individual to ride
- Inability to schedule riding time to coincide with an individual's school or work schedule

Medical Precautions and Contraindications information is available for review by request from the Program Coordinator.

Physicians Statement
All CTREE riders ***must*** have a signed and dated statement from their doctor.

Age
Therapeutic riding riders must be at least 5 years of age. Riders under the age of 5 are accepted under special circumstances.

Weight Limit
CTREE reserves the right to impose a weight limit in the event that no horse is available to safely carry a rider weighing over 170 pounds. A lower limit may be imposed if illness or injury prevents the use of a suitable horse.

Behavior
Inappropriate, unsafe or disruptive behavior or any condition where the client is harmful to him/herself or others is a contraindication to therapeutic horseback riding.

Evaluation/Re-evaluation
Each potential CTREE rider will receive an initial evaluation by a PATH Int'l. certified instructor. Based on this evaluation and the rider's medical reports, the rider will be advised if therapeutic riding is a recommended form of recreation.
Under certain conditions a rider's condition may change and a re-evaluation becomes necessary. Based on this re-evaluation, the rider may have to cease riding. A doctor's written verification is required for the rider to resume riding.

Thank you for understanding these guidelines. It is the intent of CTREE to provide the safest possible therapeutic riding lessons for our riders. If you have any questions, please do not hesitate to call us.

Authorization for Emergency Medical Treatment

☐ Participant ☐ Staff ☐ Volunteer

Name _____ DOB _____ Phone _____

Address _____

Physician's Name, Town, Phone _____

Health Insurance Company _____ Policy # _____

Allergies to medication _____

Current medications and dosage _____

Caregiver Information: Name _____ Phone _____

Cell phone numbers: _____

Address (if different than above) _____

In the event of an emergency, contact:

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 Twin Oaks Farm, Sagaponack, I authorize Center for Therapeutic Riding in the East End (CTREE) to:

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

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 none of the persons listed above are unable to be reached.

Date _____ Consent Signature _____

Client, Parent, or Legal Guardian

To my knowledge, the information I have given on this form is complete and accurate.

Date _____ Signature _____

Client, Parent, or Legal Guardian

CTREE PARTICIPANT PHYSICIAN'S FORM – PAGE 1

Date: _____

Dear Physician/Health Care Provider:

Your patient, _____, is interested in participating in supervised equine activities.
(participant's name)

In order to safely provide this service, CTREE requests that you complete/update the Physician's Form, Page 2.

Please note that the following conditions may suggest precautions and contraindications to equine activities. 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 Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities
Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia
Other
Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown
Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact me. I can be reached at 631-779-2835.

Sincerely,

Karen

Karen T. Bocksel
Managing Director

CTREE PARTICIPANT PHYSICIAN'S FORM – PAGE 2

Participant: _____ DOB: _____ **Height**: _____ **Weight**: _____
Address: _____
Diagnosis: _____ Date of Onset: _____
Past/Prospective Surgeries: _____
Medications: _____
Seizure Type: _____ Controlled? Y N Date of last seizure: _____
Special Precautions, Diets/Needs: _____
May participate in all activities _____May participate except for: _____
For those with Down Syndrome: Neurologic Symptoms of Atlantoaxial Instability: ____ Present ____ Absent

This participant is up-to-date on all the following routine childhood immunization :

	Y	**N**	Date
Measles			
Rubella			
Tetanus			
Pertussis			
Polio			
Diphtheria			
Other:			

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

IMPORTANT NOTE TO DOCTOR/MEDICAL FACILITY:
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.
Name/Title: _____ MD DO Other: _____
Signature: _____ Date: _____
Address: _____

CTREE COVID-19 LIABILITY RELEASE
WARNING: IMPORTANT NOTICE

BY SIGNING THIS AGREEMENT, YOU ARE GIVING UP CERTAIN LEGAL RIGHTS, INCLUDING THE RIGHT TO RECOVER DAMAGES IN CASE OF ILLNESS, INJURY, OR DEATH (collectively "Loss") ARISING OUT OF YOUR PRESENCE AT THE FACILITY SPECIFICALLY RELATED TO COVID-19 OR ANY OF ITS MUTATIONS, FORMS, DERIVATIVES, OR OTHER INFECTIOUS DISEASES (collectively "COVID-19").

I, the undersigned, hereby enter into this Release, Waiver, Hold Harmless, Assumption of Risk, Defend, and Indemnify Agreement for Infectious Diseases Including COVID-19 Related Loss ("**Agreement**") in consideration of my, and my minor child if applicable (collectively "**I**", "**me**", or "**my**"), ability and permission to access, utilize, occupy, visit, attend, or otherwise be present on the Twin Oaks Farm, Inc. property ("**the Facility**") during and after the COVID-19 pandemic, for any reason, whether or not related to equines or equine activities.

1. Risk of Loss/Protective Measures/No Guarantee: By signing this Agreement, I hereby acknowledge that I have familiarized myself with the risk of Loss being present at the Facility for any reason whatsoever and the protective measures at the Facility intended to minimize my risk of exposure to COVID-19. I agree the protective measures are satisfactory and sufficient for me to accept and assume the risk of my COVID-19 exposure resulting from accessing, utilizing, occupying, visiting, attending, or otherwise being at the Facility occupied by other individuals; however, I understand and agree that Released Parties cannot guarantee: (a) the protective measures can or will prevent my exposure to COVID-19; (b) will be complied with by all individuals at the Facility; or (c) that others will not act in a negligent manner that may contribute to my Loss or contraction of COVID-19. I agree to fully comply with all protective measures required by the Facility as they now exist or may be revised from time-to-time. I accept full responsibility for my own safety and the sanitization of myself and my personal property and/or other personal property I contact at the Facility. If I am a parent or legal guardian of a minor individual at the Facility, I consent to the minor's presence at the Facility and agree to remain responsible for the minor's Loss and minor's compliance with all required protective measures.

2. Medical Attention/Disclosure: I understand and agree that engaging in equine activities or merely being at the Facility exposes me to inherent risks of personal injury that may require medical attention including, but not limited to, first aid and/or emergency medical care. I therefore consent to personal contact by Released Parties and/or medical personnel deemed necessary for providing for my care at the Facility and/or the hospital, even at the risk of my COVID-19 exposure. I agree to hold Released Parties harmless for such medical attention and any Loss directly or indirectly resulting therefrom. I agree that in the event I am diagnosed as infected with COVID-19, I authorize medical personnel to provide Center for Therapeutic Riding of the East End (CTREE) and Twin Oaks Farm, Inc. information regarding my Loss and treatment for contact tracing or any other purpose.

3. Release/Hold Harmless/Defend/Indemnify: I agree to release, hold harmless, defend, and indemnify CTREE, Twin Oaks Farm, Inc., and their respective heirs, beneficiaries, relatives, agents, successors, assigns, instructors, trainers, employees, volunteers, independent contractors, working students, assistants, sponsors, guests, visitors, members, managers, officers, directors, owners, related entities, and others acting on their behalf (collectively "**Released Parties**") from and against any liability, attorneys' fees, costs, or other Loss I may incur arising out of or in any way connected with my exposure to or contraction of COVID-19 as a direct or indirect result of my presence at the Facility whether by my negligence or the negligence or other wrong doing of Released Parties (other than gross negligence, willful and wanton, or intentional misconduct).

WARNING

BEFORE SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND ALL OF THE INFORMATION CONTAINED THEREIN. I ACKNOWLEDGE THAT I DO NOT NEED ANY FURTHER EXPLANATION OF ITS CONTENTS AND WAIVE ANY FURTHER EXPLANATION. I HAVE VOLUNTARILY AGREED TO ITS TERMS AND PROVISIONS, UNDERSTAND AND AGREE THAT I HAVE OTHER FACILITIES TO CHOSE FROM, AND AGREE THAT NO OTHER STATEMENT, REPRESENTATIONS OR INDUCEMENT, APART FROM WHAT IS STATED IN THIS AGREEMENT, HAVE BEEN MADE TO ME TO OBTAIN MY CONSENT AND MY SIGNATURE.

Date:_____ Printed Name:_____

Minor Participant Name:_____ Minor Volunteer Name:_____

Signature: (on my own behalf or on behalf of a minor, if applicable):_____

Address: _____

Phone:_____ Email:_____

Emergency Contact (name and phone #):_____