



PARTICIPANT APPLICATION

Participant's Name: _____ Date of Birth: ____/____/____ Age: _____

Parent/Guardian Name _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____ Email*: _____

*Please include an email address. We like to be able to post barn updates and events without having to bother you on the phone.

Disability: _____ Weight: _____

Special Medical Conditions: _____

Participant Selection

As a process of assuring the benefits of each participant at Courage Reins, the staff selects participants for the program based on horse suitability and availability (including the weight carrying limits of each horse), availability of volunteers, access to therapists, the age, weight, and needs of the rider. Courage Reins is designed to meet the needs of individuals with disabilities; however, there are some precautions and contraindications, limitations, and challenges that may prevent Courage Reins from successfully providing therapeutic riding activities to some individuals. Maximum Weight Limit for participants is 200lbs dependent upon ambulatory status, rage of motion, weight carrying limits of available horses, and discretion of the Program Director. Participants over this weight are invited to participate in un-mounted activities such as our Natural Horsemanship program.

LIABILITY RELEASE

I acknowledge the risks and potential risks of horseback riding and working with horses. I assume all such risks. I certify that I have adequate insurance to cover any injury or damage I may cause or suffer while participating, or else I agree to bear the costs of such injury or damage myself. I hereby, intending to be legally bound for myself, my heir and assign, executors or administrators, waive and release forever all claims for damages against COURAGE REINS, INC., its Board of Trustees, Instructors, Therapists, Aides, Volunteers, Employees and/or Owners of Horses in use at the facility for any and all injuries and/or losses I may sustain while participating as a COURAGE REINS rider.

PHOTO RELEASE

I hereby grant Courage Reins the right and permission to publish & display all photographs, slides and visually recorded images in which I appear in whole or part. I hereby waive any right that I may have to inspect and/or approve the finished product or editorial layout that may be used in connection there within. The photograph(s) will only be used by Courage Reins for the sole purpose of promoting the mission of the center for those with disabilities and special needs.

REVIEW GENERAL INFORMATION ABOUT ATTENDANCE STANDARDS

Participation in our program, like other activities, such as soccer, dance, gymnastics, etc., is purchased as a package. Full attendance is your responsibility. Please contact the Executive Director if some serious circumstance prevents you from honoring your contract

- We will, however, organize each color or type of class into an email directory where you could communicate with each other to swap class days and times, as needed, so long as we get a 24 hour notice to adjust the riding schedule.
- Cancelled lessons by the Center will be made up at a time convenient to you during our normal operating hours or the lesson will be credited to your account.

FINANCIAL RESPONSIBILITY

By signing below I agree to pay all amount(s) owed within the period of contracted sessions in which the amount(s) are incurred. I agree that interest will accrue on all past-due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principal amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

Sign to acknowledge that you have read, understood and accepted the conditions above.

Signature: _____ Date: _____

Intake Questionnaire

Participant: _____

Minor's Parents' Names: _____

Services you are seeking:

- Natural Horsemanship
- Enhanced/Hippo Therapy
- Equine Assisted Psychotherapy & Learning
- Therapeutic Riding

Please indicate the participants areas of concern, please mark all that apply.

| Areas | Yes | No | Comments |
|-----------------------------|-----|----|----------|
| Range of motion/flexibility | | | |
| Strength | | | |
| Mobility | | | |
| Balance | | | |
| Coordination | | | |
| Sensory | | | |
| Behavior | | | |
| Physical fitness | | | |
| Social skills | | | |
| Communication | | | |
| Other | | | |

Main concern you wish to be addressed:

Has the participant previously received therapeutic services before, and if so, when and why?

Does the participant have a history of mental health concerns such as anxiety, depression, substance abuse, cutting or other forms of self-harm, suicide attempts, psychosis? If so, please describe.

Is the participant currently under the care of a mental health professional? If so, please describe the nature of the treatment.

Does the participant have a history of physical, mental, sexual abuse or neglect?

Does the participant have any acute or chronic physical concerns?

What are the participants current symptoms, physical or emotional?

Please indicate the participants cognitive ability of the following areas below.

| Areas | Yes | No | Comments |
|--------------------------------|-----|----|----------|
| Knows Colors | | | |
| Knows Numbers | | | |
| Knows Letters | | | |
| Knows Shapes | | | |
| Able Read | | | |
| Knows Sign Language | | | |
| Speaks Verbally | | | |
| Understands verbal cues | | | |
| Short Attention Span | | | |
| Easily Distracted | | | |
| Any Special Precautions | | | |

Please indicate the participants social skills below.

| Areas | Yes | No | Comments |
|--------------------------------|-----|----|----------|
| Eye Contact | | | |
| Follows Commands | | | |
| Cooperates | | | |
| Interacts with others | | | |
| Any Special Precautions | | | |

Please indicate the participants sensorimotor abilities below.

| Areas | Yes | No | Comments |
|--------------------------------|-----|----|----------|
| Vision | | | |
| Hearing | | | |
| Tactile (hypersensitivities) | | | |
| Body Awareness | | | |
| Fine Motor Skills | | | |
| Gross Motor Skills | | | |
| Any Special Precautions | | | |

What triggers negative reactions? How are negative reactions exhibited?

Any other issues we should be aware of?

Goals for Treatment:

- Peer Interaction
- Social Skills
- Behavioral Improvements
- Physical Improvements

Other:

Participant Name (Print) _____ Participant Signature _____ Date _____

Parent/Guardian Name (Print) _____ Parent/Guardian Signature _____ Date _____