Cloud Dancers
THERAPEUTIC HORSEMANSHIP

Annual Rider Application

Please Email Completed Form to programs.clouddancersthp@gmail.com
OR Mail to PO Box 10489 Albuquerque, NM 87184

Rider Name: _____ DOB: _____ Today's Date: _____

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

Parent/Legal Guardian's Name: _____

Phones: (H) _____ (C) _____ (W) _____ Email: _____

Height: _____ Weight: _____

How did you hear about Cloud Dancers? _____

Please complete the below. Describe the rider's abilities/difficulties in the following areas (include assistance required or equipment needed):

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

_____

_____

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

_____

_____

OTHER THERAPIES (Has the rider ever received any type of therapy such as Physical Therapy, Speech-Language Therapy, or Occupational Therapy? If yes, indicate which one(s) and when received.)

_____

_____

Please indicate availability ☐ Mon.-Fri. ☐ Sat.-Sun. ☐ Morning ☐ Afternoon ☐ Evening ☐ Group Lesson ☐ Private Lesson

How will you pay for lessons? ☐ Private ☐ DD Waiver (self-directed) ☐ CD Assistance ☐ Other

Rider or Parent/Legal Guardian Signature: _____ **Date:** _____

CD Staff Initials: _____ Date: _____

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Authorization for Emergency Medical Treatment

Rider Name: _____ Physician's Name: _____

Preferred Medical Facility: _____

Health Ins. Co.: _____Policy #: _____Allergies: _____

Current medications: _____

IN THE EVENT OF AN EMERGENCY, CONTACT:

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

PARENT/LEGAL GUARDIAN (if applicable):

Parent/Legal Guardian's Name: _____

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

Phones: (H) _____ (C) _____ (W) _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, while being on the property where the riding program operates, or in participating in other program activities, I authorize Cloud Dancers Therapeutic Horsemanship Program, Inc. to:

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

Select ONE of the Plans Below

CONSENT Plan

This authorization includes x-ray, surgery, medication, hospitalization, and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Consent Name (Print): _____
Rider or Parent/Legal Guardian

Consent Name 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 where the riding program operates.

Parent or legal guardian will remain on site at all times during equine assisted activities.

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

_____

_____

Non-Consent Name (Print): _____
Rider or Parent/ Legal Guardian

Non-Consent Name Signature: _____

Date: _____

CD Staff Initials: _____ Date: _____

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Annual Rider Goal List

Rider Name: _____ Date: _____

Age: _____ Form Completed By: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Our instructors would like to know the important life goal that the rider/you is working towards. This information helps us to structure our lesson plans (i.e. walking without assistance, independent living, decision making, etc).

1. What is a major life goal?

_____

_____

2. Please select **up to 2 goals in each category** (i.e. Balance, Confidence, Concentration, etc) that are most important. **Rank them 1 or 2** with 1 being the most important.

Physical Goals		Social Goals		Cognitive Goals	
Balance		**Socialization**		**Readiness Skills**	
	Posture		Enjoyment		Verbal skills/Vocalizations
			Participation		Vocabulary Expansion
			Sportsmanship		Word Recognition/Reading Skills
					Math Skills
					Shape Recognition
					Color Identification
Coordination		**Confidence**		**Decision Making**	
	Fine Motor Skills		Self-esteem		Sequencing
	Range of Motion		Responsibility		
	Spatial Awareness		Independence		
Strength		**Communication**		**Concentration**	
	Head Control		Cooperation		Focus
	Gross Motor Skill		Transition between activities		Attention (increase)
	Muscle tone (increase)				Attention (decrease)
	Muscle tone (decrease)				

Other: _____ Other: _____

If needed, what behavior modification techniques would you suggest or recommend instructors use in the barn and during lesson if the rider is experiencing a challenge? _____

_____

Questions? Contact Karen Molony at 505-235-8358 or karen.clouddancersthp@gmail.com.

CD Staff Initials: _____ Date: _____

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Rider/Parent Acknowledgement of Covid Risk

I, _____(Print Name), am aware of the risks of contracting COVID 19 while receiving in-person services from Cloud Dancers Therapeutic Horsemanship. I acknowledge that certain at-risk populations such as persons over age 60 and those with underlying medical conditions are more susceptible to the disease.

I am also aware that face-to-face services increase my risk of contracting and passing on COVID 19. Cloud Dancers cannot guarantee social distancing where support or assistance is needed to mount/dismount, balance or sit upright on a horse, address bodily fluid from the facial area, or in cases of emergencies or other unforeseen circumstances.

I have read Cloud Dancers Rider and Family Information and Volunteer packets relative to COVID 19, our Cleaning & Disinfecting Protocol for Prevention of the Spread of COVID 19 and agree to follow these guidelines, as well as, the Governor's, New Mexico Department of Health and CDC mandates as they relate to COVID 19.

I knowingly accept the additional risks stated above, despite reasonable precautions, and agree to release, acquit, discharge and hold harmless Cloud Dancers Therapeutic Horsemanship Program, Inc., its officers, trustees, agents, employees, contractors, representatives, staff, volunteers, successors, and assigns, for all manner of claims, demands and damages of every kind and nature whatsoever, which the undersigned may now, or in the future, have against Cloud Dancers related to any matters associated with COVID 19.

Rider or Parent/Legal Guardian (Print): _____

Rider or Parent/Legal Guardian Signature: _____ **Date:** _____

CD Staff Initials: _____ Date: _____

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Liability Release (Required)

The undersigned, a rider, or the undersigned, as parent(s) or legal guardian(s) of _____, a rider, for and in consideration of the agreement of Cloud Dancers Therapeutic Horsemanship Program, Inc. to provide equine assisted activities to said rider, does/do hereby forever release, acquit, discharge and hold harmless Cloud Dancers Therapeutic Horsemanship Program, Inc., its officers, trustees, agents, employees, representatives, staff, volunteers, successors and assigns, for all manner of claims, demands and damages of every kind and nature whatsoever, which the undersigned or said rider may now, or in the future, have against Cloud Dancers Therapeutic Horsemanship Program, Inc., its officers, trustees, agents, employees, representatives, staff, volunteers, successors and assigns on account of any personal injuries, physical or mental condition, known or unknown, to the person of said rider and the treatment therefore as a result of, or in any way growing out of, the acts of Cloud Dancers Therapeutic Horsemanship Program, Inc., its officers, trustees, agents, employees, representatives, staff, volunteers, successors and assigns, including, but not limited to, their negligence or gross negligence, in rendering the services above described or in any way incidental thereto.

Rider or Parent/Legal Guardian (Print): _____

Rider or Parent/Legal Guardian Signature: _____ **Date:** _____

Photo/Media Release (Optional)

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grant to Cloud Dancers Therapeutic Horsemanship Program, Inc., permission to take or have taken, still or moving photographs and films including television picture of _____, a rider, of Cloud Dancers Therapeutic Horsemanship Program, Inc. I/we further consent and authorize Cloud Dancers Therapeutic Horsemanship Program, Inc., its advertising agencies, news media, and any other persons interested in Cloud Dancers Therapeutic Horsemanship Program, Inc., and its work, to use and reproduce the photographs, films and pictures to circulate and publicize the same by all means including without the generality of the foregoing newspapers, web site, television media, brochures, pamphlets, instructional materials, books, and clinical material. With regard to the foregoing material, no inducements or promises have been made to us/me to secure our/my signature(s) on this release other than the intention of Cloud Dancers Therapeutic Horsemanship Program, Inc. to use or be used such photographs, films and pictures for the primary purpose of promoting and aiding Cloud Dancers Therapeutic Horsemanship Program, Inc., and its work. I/we understand that this permission is not restricted to the duration of time the above-named rider is a registered rider in a Cloud Dancers Therapeutic Horsemanship Program. I/we further understand that I/we can reverse this permission at any time by submitting a written statement to that effect to Cloud Dancers Therapeutic Horsemanship Program, Inc., P.O. Box 10489, Albuquerque, NM 87184.

Rider or Parent/Legal Guardian (Print): _____

Rider or Parent/Legal Guardian Signature: _____ **Date:** _____

CD Staff Initials: _____ Date: _____