



4705 Winkler Road\*Philpot, KY 42366  
(270) 613-0079

**2023 Dream Riders of Kentucky Inc. Participant Package Check List**

All of the forms listed below are required to be completed, checked, signed and dated as indicated prior to the start of rider participation and annually thereafter.

**Participant name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**To be completed by participant, parent or caregiver.**

- 1. Participant package check list
- 2. Participant registration form
- 3. Contact and tuition payment
- 4. Participant Release
- a) Liability release
- b) Confidentiality agreement
- c) Photo and video release
- 5. Annual Health History and Contact Information Update Form
- 6. Possible reasons for discharge form
- 7. Participant goal sheet
- X **8. Information for Physician** (To be handed to the physician with forms 9 and 10)

**To be completed by the participant's physician**

- 9. Rider health history/physician assessment form
- 10. Physician release (all riders must have a signed release)
- b) Neurological exam results for Atlanto-axial Instability for persons with Down Syndrome (if applicable)

**Optional Information if applicable to the participant's goals/needs**

- 11. Physical/Occupational/Speech Therapy Forms
- 12. I.E.P. Individual Education Plan

**For office use only**

Forms	1	2	3	4	5	6	7	8	9	10	11	12
								X				

# Dream Riders of Kentucky Participant Registration Form

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## 2023 Program Information:

Date \_\_\_\_\_

Participant Name: \_\_\_\_\_ Phone: \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Gender M F

Primary Diagnosis \_\_\_\_\_

Secondary Diagnosis \_\_\_\_\_

Mobility status (walks unassisted, assistive devices, etc.) \_\_\_\_\_

Address \_\_\_\_\_

Communication (verbal, non-verbal signs) \_\_\_\_\_

Behaviors (impulsive, fearful, frustration tolerance) \_\_\_\_\_

Medications Taken \_\_\_\_\_

Seizures (if applicable please describe) \_\_\_\_\_

Limitations \_\_\_\_\_

Allergies \_\_\_\_\_

Skin sensitivity \_\_\_\_\_

Participant's occupation/ school grade level \_\_\_\_\_

Affiliate Program if applicable \_\_\_\_\_

**Personal Goals** (fill in the areas that apply) \_\_\_\_\_

Physical \_\_\_\_\_

Cognitive \_\_\_\_\_

Social/Behavioral \_\_\_\_\_

Emotional \_\_\_\_\_

Life skills \_\_\_\_\_

**Availability for the DREAM RIDERS OF KENTUCKY, INC. Program** (Check all available times and days)

- |  |  |   |                                      |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Tuesday am        | <input type="checkbox"/> Wednesday am        | <input type="checkbox"/> Thursday am        | <input type="checkbox"/> Saturday am |
| <input type="checkbox"/> Tuesday afternoon | <input type="checkbox"/> Wednesday afternoon | <input type="checkbox"/> Thursday afternoon | <input type="checkbox"/> Saturday pm |
| <input type="checkbox"/> Tuesday evening   | <input type="checkbox"/> Wednesday evening   | <input type="checkbox"/> Thursday evening   | <input type="checkbox"/> Other _____ |

## For staff use only:

Start Date \_\_\_\_\_

Confirmed Day: \_\_\_\_\_ Time: \_\_\_\_\_



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### 2023 Dream Riders Participant Contact and Tuition Information

Participant Name: \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Email Address \_\_\_\_\_

Names of parents/guardian:

Father \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Mother \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Best Emergency Contact: Name \_\_\_\_\_

Phone \_\_\_\_\_ Cell \_\_\_\_\_

Parent occupation and employer:

Father \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother \_\_\_\_\_ Work Phone \_\_\_\_\_

How were you referred to **DREAM RIDERS OF KENTUCKY, INC.?** \_\_\_\_\_

### 2023 Program Tuition Payment Details

Please let us know your method of payment:

- Check (please make payable to Dream Riders of Kentucky Inc.)
- Cash       PayPal (DRK website)       Credit card (DRK website)

I understand and agree that all paperwork must be up to date in the calendar year in which I am participating. All tuition is to be paid prior to the start of each semester. The rate for each semester is \$150. If applicable, all scholarship forms must accompany the rider application. Scholarships are available for those who qualify, please contact the Program Director for further information. In no way does Dream Riders of Kentucky Inc. want to turn anyone away due to financial constraints.

Signature of Participant or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

**2023 DREAM RIDERS of KENTUCKY**  
**4705 Winkler Road\*Philpot, KY 42366**  
**(270) 613-0079**

**Participant Liability Release, Confidentiality Agreement, Photo and Video Release**

Participant Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian/ Conservator (if applicable) \_\_\_\_\_

**Liability Release:**

Name of Parent/Guardian/Conservator \_\_\_\_\_

I acknowledge the risks and potential risks for horseback riding and activities in and around a facility where horses are kept, and farm machinery operated. However, I feel that the possible benefits to me/my son/my daughter/my ward are greater than the risk assumed. Intending legally to bind myself, my heirs, and assigns, executors or administrators, I hereby waive and release forever all claims for loss or damages of any kind against **DREAM RIDERS OF KENTUCKY, INC.**, its Board of Directors, Instructors, Therapists, aids, Volunteers and employees for any and all injuries and losses that I/my son/my daughter/my ward may sustain while participating in the **DREAM RIDERS OF KENTUCKY, INC.** program. This release includes without limitation the risk of negligent instruction and supervision. I engage in activities at **DREAM RIDERS OF KENTUCKY, INC.** voluntarily with knowledge of the risks and I assume all risks of injury, death, and property damage that may result. I agree to bear any loss myself. I acknowledge that **DREAM RIDERS OF KENTUCKY, INC.** and the property owners are materially relying on this waiver and assumption of risk in allowing me/my son/my daughter/my ward to participate in activities at **DREAM RIDERS OF KENTUCKY, INC.**

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

(Participant, Parent or Caregiver)

**Confidentiality Agreement:**

I understand that all the personal information (written and verbal) about participants at **DREAM RIDERS OF KENTUCKY, INC.** is confidential and not to be shared with anyone without expressed written consent of the participant and their parent/guardian in the case of a minor.

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

(Participant, Parent or Caregiver)

**Photo and Video Release:**

- I consent to and authorize
- I do not consent to nor do I authorize

The use and reproduction by **DREAM RIDERS OF KENTUCKY, INC.** of any other audio/visual materials taken of me/my son/my daughter/my ward for distribution to the public for promotional printed materials, educational activities or for any other use for the benefit of the program.

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

(Participant, Parent or Caregiver)

**2023 Dream Riders of Kentucky**  
**Annual Health History and Contact Information Update Form**

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

Name of Participant: \_\_\_\_\_

Name of Parents/Guardian (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail: (Please print clearly and carefully) \_\_\_\_\_

Participant DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Diagnosis + changes \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

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

Preferred Medical Facility: \_\_\_\_\_ Physicians Name: \_\_\_\_\_

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

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

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

Precautions/Restrictions: \_\_\_\_\_

Please explain any recent changes in health or behavior status:

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

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

Print Name and Relationship: \_\_\_\_\_



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## 2023 Dream Riders of Kentucky Inc. Participant Discharge Form

Please be advised of the following reasons that may lead to discharge from the riding program.

1. The client has reached all of their goals and is ready to graduate.
2. The client's potential to maintain head and neck control while riding presents a safety concern.
3. Inability to follow directions is interfering with progress toward goals.
4. Uncontrolled and/or inappropriate behavior that constitutes a safety risk to client, staff and/or horse.
5. Client exceeds weight that can safely be managed by staff, volunteers, and/or horses.
6. Any change in the client's medical, physical, cognitive, or emotional condition that makes therapeutic riding inappropriate.
7. Three scheduled appointments are missed without prior cancelation.
8. Non-payment of fees as originally agreed.

I understand and agree with the possible reasons for client discharge.

Signature of Participant or Legal Guardian: \_\_\_\_\_

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



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## 2023 Dream Riders of Kentucky Inc. Participant Goal Sheet

**Please help us help you get the most out of your classes by filling out the following goal setting sheet. Goal setting is applicable for all types of classes offered at DRK.**

**Thank you.**

Participant name: \_\_\_\_\_

Parent name: \_\_\_\_\_

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

Class day/time: \_\_\_\_\_

The following categories are meant as a guideline and all categories may not apply to all students.

Personal riding goals: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physical goals: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Social goals: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Emotional/behavioral Goals \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Long-term goal over the next year. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Goals Dated: \_\_\_\_\_



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## 2023 Dream Riders of Kentucky Information for Physician

The following conditions, if present, may represent precautions or contraindications to Dream Riders programs. **Please complete the Dream Riders of Kentucky, Inc. Medical Release and Health History Assessment form. Also, please note if any of the following conditions are present, and to what level of involvement. Thank you.**

### Orthopedic

Spinal Fusion  
Spinal Instabilities/Abnormalities  
Atlantoaxial Instabilities  
Scoliosis  
Kyphosis  
Lordosis  
Hip Subluxation and Dislocation  
Osteoporosis  
Pathological Fractures  
Coxas Arthrosis  
Heterotopic Ossification  
Cranial Deficits  
Spinal Orthoses  
Internal Spinal Stabilization Devices

### Medical/Surgical

Allergies  
Cancer  
Poor Endurance  
Recent Surgery  
Diabetes  
Peripheral Vascular Disease  
Varicose Veins  
Hemophilia  
Hypertension  
Serious Heart Condition  
Stroke (Cerebrovascular Accident)

### Neurological

Hydrocephalus/shunt  
Spina Bifida  
Tethered Cord  
Chiari II Malformation  
Hydromyelia  
Paralysis due to Spinal Cord Injury  
Seizure Disorders

### Secondary Concerns

Behavior Problems  
Age under Two Years  
Age Two - Four Years  
Indwelling Catheter  
Acute Exacerbation of  
Chronic Disorder

**(Please give to the participant's physician as a guideline for participation in any of the Dream Riders of Kentucky Inc. programs)**



## 2023 Dream Riders of Kentucky Inc. Annual Participant Health History

Participant Name \_\_\_\_\_ DOB \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Address \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset \_\_\_\_\_

Past/Prospective Surgeries: \_\_\_\_\_

Medications \_\_\_\_\_

Seizures Y N Type \_\_\_\_\_ Controlled Y N Date of Last Seizure \_\_\_\_\_

Shunts/Implants/Appliances \_\_\_\_\_

Hospitalizations/Surgery \_\_\_\_\_

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Neurologic Symptoms of Atlanto Axial Instability Yes No \_\_\_\_\_

Please indicate and comment on any Special Problem Areas Below:

Area	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological/Sensation			
Bowel/Bladder			
Muscular			
Orthopedic			
Allergies			
Behavior			
Cognition			
Emotional/Psychological			
Other			

**2023 DREAM RIDERS of KENTUCKY Inc. Physician Release**

Participant name: \_\_\_\_\_

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that **DREAM RIDERS OF KENTUCKY, INC.** will weigh the medical information contained in the physician release form against existing PATH Intl. precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional) e.g. PT, OT, Therapist, Psychologist, etc.) In the implementing of an effective equestrian program.

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

Physician's name, address, and telephone number: **(please print, type or stamp):**

**Physician Annual Medical Clearance report for Neurologic Symptoms of Atlanto Axial Instability Exam.**

**For All Participants with Down syndrome:**

\_\_\_\_\_ has undergone a neurological exam by a licensed physician to test for symptoms consistent with atlantoaxial instability.

\_\_\_\_\_ has been given medical clearance by the licensed physician below, due to the results of the neurological exam that denies any symptoms consistent with atlantoaxial instability.

Physician name: \_\_\_\_\_

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

Physician's name, address, and telephone number: **(please print, type or stamp):**

Updated: January 2023