Pacific Riding for Developing Abilities

1088 – 208th Street, Langley BC, V2Z 1T4 • Phone: 604-530-8717 • Fax: 604-530-8617
www.prda.ca • Business # 11907 5620 RR0001

Dear Potential Rider/Parent/Guardian:

Thank-you for your interest in our programs here at Pacific Riding for Developing Abilities. Enclosed you will find:

1. Letter for the Applicant's Physician
2. Physician's Referral Form
3. List of Precautions and Contraindications
4. Parent/Guardian Release and Waiver of Liability
5. Photo Release Form
6. Authorization for Emergency Medical Treatment Form

Please give items 1, 2, and 3 to the applicant's physician and have the physician complete the Physician's Referral Form. As well, the applicant or parent/guardian of the applicant must complete items 4, 5, and 6. All original forms should be returned to us either by mail or in person.

Once these forms are received, the applicant will be placed on our waiting list. When a suitable spot becomes available, they will be contacted to arrange an assessment with the Instruction Coordinator. This is so we can have a face-to-face meeting with the potential participant and assess their suitability for the program, horse requirement and any special equipment and volunteers that may be required.

Once again, thank you for your inquiry into our programs. Please feel free to stop by anytime and have a look around and meet our horses and staff. If you have any questions, please feel free to call us at 604-530-8717.

Sincerely,

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Dear Doctor:

Thank you for completing the Physician's Referral Form for your patient to participate in one of our programs at Pacific Riding for Developing Abilities. Your comments will greatly help our Instructors provide a better quality program for the applicant. Where possible, be specific with your comments.

Please take some time to review the list of Contraindications and Precautions, and consider the ones that may be applicable to your patient. If you have any questions or concerns, please contact the PRDA office at 604-530-8717. Further, please review the list of conditions that require a cervical spine and/or flexion/extension x-ray. If an x-ray is indicated, please attach a copy of the results to this Referral.

When a suitable spot for your patient becomes available, he/she will be contacted to arrange an assessment with the Instruction Coordinator at PRDA. This is so we can have a face-to-face meeting with the potential participant and assess their suitability for the program, horse requirements, and any special equipment and volunteers that may be required.

Riding is considered a high-risk sport, therefore the highest safety standards are always maintained at PRDA. Our Coaches are all certified, with knowledge of teaching in a therapeutic riding setting, and are familiar with people with both physical and/or cognitive disabilities. Our Instructors are working towards Coaching certification, and are mentored and supervised by Coaching staff.

Thank you again for completing the Physician's Referral Form. If you have any questions or concerns regarding your patient's participation in our program, or have any other questions about PRDA or therapeutic riding in general, please do not hesitate to call our office.

Sincerely,

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PHYSICIAN'S REFERRAL

NAME OF RIDER		PHONE	
ADDRESS		CITY/POSTAL CODE	
GENDER	DATE OF BIRTH	WEIGHT	HEIGHT
DIAGNOSIS	DATE OF ONSET	EMAIL ADDRESS	

RIDER'S PATENT/GUARDIAN/CONTACT NAME	PHONE

PLEASE BE SPECIFIC WHEN COMMENTING ON IMPAIRMENTS

AUDITORY IMPAIRMENTS	NO	YES	
SPEECH IMPAIRMENTS	NO	YES	
ORAL MOTOR FUNCTION	NORMAL	ABNORMAL	
VISUAL IMPAIRMENTS	NO	YES	
PSYCHOLOGICAL OR BEHAVIOURAL CONCERNS	NO	YES	
CIRCULATORY IMPAIRMENTS	NO	YES	
SENSATION	YES	NO (WHERE)	
INCONTINENCE	BOWEL	NO	YES
	BLADDER	NO	YES
SPINAL/JOINT ABNORMALITIES	NO	YES	
HIP SUBLUXATION OR DISLOCATION	NO	YES	
COORDINATION IN UPPER EXTREMITIES	NORMAL	ABNORMAL	GROSSLY ABNORMAL
COORDINATION IN LOWER EXTREMITIES	NORMAL	ABNORMAL	GROSSLY ABNORMAL

MISSION STATEMENT

Through equestrian activities and with the involvement of the community, we enhance the quality of life for individuals with a wide range of challenges.

MUSCLE TONE	**ARMS**	NORMAL	HIGH TONE	LOW TONE
	LEGS	NORMAL	HIGH TONE	LOW TONE
	TRUNK AND NECK	NORMAL	HIGH TONE	LOW TONE
BALANCE	**STATIC SITTING**	GOOD	FAIR	POOR
	DYNAMIC SITTING	GOOD	FAIR	POOR
	STATIC STANDING	GOOD	FAIR	POOR
	DYNAMIC STANDING	GOOD	FAIR	POOR

SEIZURES (SEE LIST IF CONTRAINDICATIONS)		NONE	YES (LIST TYPE)
		PRE-SEIZURE INDICATORS	DATE OF LAST SEIZURE
MEDICATIONS	NONE	YES (PLEASE SPECIFY)	
MEDICATION SIDE EFFECTS	NONE	YES (PLEASE SPECIFY)	
RELEVANT SURGERIES AND DATE			
LAST TETANUS VACCINATION DATE			
ALLERGIES			

ASSISTIVE DEVICES OR BRACES	NONE	YES (PLEASE STATE)
DOWNS SYNDROME & RHEUMATOID CERVICAL SPINE X-RAYS (SUB OCCIPITAL & ATLANTO/AXIAL JOINTS)* (SEE LIST OF CONTRAINDICATIONS)		YEAR
FLEXION/EXTENSION X-RAYS REQUIRES* (SEE LIST OF CONTRAINDICATIONS)		YEAR

*WHEN APPLICABLE, PLEASE INCLUDE A COPY OF CERVICAL SPINE OR FLEXION/EXTENSION X-RAY REPORT

IN MY OPINION, THIS PATIENT CAN RECEIVE THERAPEUTIC HORSEBACK RIDING LESSONS UNDER PROPER INSTRUCTION. I UNDERSTAND THAT THIS PATIENT MAY RECEIVE ASSESSMENT/TREATMENT BY A VOLUNTEER PHYSIOTHERAPIST OR OCCUPATIONAL THERAPIST, IN CONJUNCTION WITH THIS RIDING PROGRAM REGARDING HIS/HER PHYSICAL AND/OR BEHAVIOURAL ABILITIES/LIMITATIONS IN PERFORMING WITH THIS PROGRAM.

COMMENTS

DR'S STAMP – NAME/ADDRESS/PHONE (REQUIRED)	**SIGNATURE**
	DATE

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GUIDELINES FOR PHYSICIANS/THERAPISTS

CONTRAINDICATIONS AND PRECAUTIONS FOR THERAPEUTIC RIDING

The following conditions may represent precautions or contraindications to therapeutic horseback riding if present in potential students. Therefore, when completing the Physician's Referral, please note whether these conditions are present and to what degree.

ABSOLUTE CONTRAINDICATIONS

ORTHOPEDIC:

- Acute arthritis
- Acute herniated or prolapsed disc
- Atlanto-axial instabilities
- Coxa athrosis (degeneration of hip joint)
- Structural cranial deficits
- Osteogenesis imperfecta
- Pathological fractures
- Spondylothesis
- Structural scoliosis >30 degrees, excessive kyphosis or lordosis or hemivertebra
- Spinal stenosis

NEUROLOGICAL:

- CVA 2nd to unclipped aneurysm or angioma
- Paralysis due to spinal cord injury above T6 (adult)
- Spina bifida associations – Chiari II Malformation, Hydromyelia, Tethered Cord
- Uncontrolled (grand mal) seizures within last 6 months

MEDICAL/PSYCHOLOGICAL:

- Obesity >170 lbs
- Andcoaguiams

OTHER:

- Age under 2 years old
- Any condition that the instructor, therapist, physician or program does not feel comfortable treating

RELATIVE CONTRAINDICATIONS AND PRECAUTIONS

ORTHOPEDIC:

- Arthrogryposis
- Heterotrophic ossification
- Hip subluxation, dislocation or dysphasia
- Osteoporosis
- Spinal fusion/fixation, Harrington Rods (within 2 years of surgery)
- Spinal instabilities/abnormalities
- Spinal orthoses

NEUROLOGIC:

- Neuromuscular disorders: Amyotrophic Lateral Scleroses, Fibromyalgia, Gullian Barre, exacerbation of Multiple Sclerosis, Post Polio Syndrome
- Hydrocephalic shunt

MEDICAL/PSYCHOSOCIAL:

- Abusive or disruptive behavior
- Cancer
- Hemophilia
- History of skin breakdown or skin grafts
- Abnormal fatigue
- Incontinence (must wear protection)
- Peripheral vascular disease
- Sensory deficits
- Serious heart condition or hypertension
- Significant allergies
- Surgery within the last three months
- Uncontrolled diabetes
- Indwelling catheter
- Substance abuse

FLEXION/EXTENSION X-RAY REQUIRED FOR ATRAUMATIC FACTORS THAT MAY BE ASSOCIATED WITH AN UNSTABLE UPPER CERVICAL SPINE:

- Os odontoidum
- Down syndrome
- Athetoid cerebral palsy
- Rheumatoid arthritis of cervical vertebrae
- Congenital torticollis
- Sprengel deformity
- Ankylosing Sponylitis
- Congenital atlato-occipital instability
- Klippel-Fwil syndrome
- Chairi malformation with cfondylar hydroplasia
- Fusion of C2-C3
- Lateral mass degeneration change at C1-C2
- Systemic lupus
- Morquio disease
- Non-rheumatoid cranial settling
- Subluxation of upper cervical vertebrae due to tumors or infections
- Idiopathic laxity if the ligaments
- Grisel's syndrome
- Lesch-Nyhan syndrome
- Marshall-Smith syndrome
- Diffuse idiopathic hyperostosis
- Congenital chondrodysplasia

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RELEASE AND WAIVER OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT

(Rider Under 19)

Pacific Riding for Developing Abilities takes every precaution to ensure a safe and secure environment. However, despite taking all efforts to provide a safe environment we must warn those using the facility that there are inherent dangers associated with horse riding facilities.

We (I), _____, hereby acknowledge and agree that in consideration of _____ (name of participant) being permitted to participate as a rider for Pacific Riding for Developing Abilities we (I) release Pacific Riding for Developing Abilities, their employees, directors, agents, independent contractors, subcontractors, representatives, sponsors, volunteers, successors and assigns (referred to collectively as PRDA) from all liability, claims, causes of action of any kid whatsoever in respect of all personal/bodily injury, death or property loss which I might suffer resulting from any cause whatsoever including but not limited to:

- The risks, dangers and hazards of being around and/or riding horses,
- The risks, dangers and hazards associated with participating in a therapeutic riding program,
- Risks, dangers and hazards associated with being around barn, arena and farm equipment
- Any loss or injury caused by negligence, breach of contract or breach of statutory duty of care on the part of PRDA.

We (I) acknowledge that participation in riding activities for PRDA involves working with and around horses in barns, arenas, and outdoors and working with riders of various ages with physical and cognitive challenges. These activities can be dangerous and expose our child/ward to risk of injury and/or death and/or property damage and we (I) freely and voluntarily assume all such risks for our child/ward.

We (I) hereby agree this Release and Waiver of Liability and Assumption of Risk extends to all acts or omissions including those constituting negligence by PRDA and is intended to be as broad and inclusive as is permitted by the laws of British Columbia and if any portion thereof is held to be invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

WE (I) HAVE READ THIS RELEASE AND WAIVER OF LIABILITY AND ASSUMPTION OF RISK AND FULLY UNDERSTAND ITS TERMS AND UNDERSTAND THAT I HAVE GIVEN UP ESSENTIAL LEGAL RIGHTS BY SIGNING IT. WE (I) HAVE SIGNED IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT, ASSURANCE, OR GUARANTEE BEING MADE AND INTENDED OUR (MY) SIGNATURE TO BE COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW.

_____ _____

Parent/Guardian's Signature *Witness' Signature*

_____ _____

Dated *Print Witness Name*

_____

Telephone Number

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PHOTO/INFORMATION RELEASE CONSENT FORM

(Rider Under 19)

We (I), _____, hereby give any person authorized by Pacific Riding for Developing Abilities (PRDA) permission to take still and moving photographs and video recordings accompanied by verbal or written identification of our child/ward, _____ (name of rider), and we (I) give consent to PRDA to use, reproduce, publish, or otherwise circulate such photographs and/or video recordings in promotion of PRDA.

We (I) permit the following Information about the rider to be published:

Name:_____

Age:_____

Special Challenges:_____

_____ _____

Date Signature of Parent/Guardian

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RIDER'S AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

In the event emergency medical aid/treatment is required due to illness or injury during the process or receiving services, or while being on the property of the agency, I authorize _____(Operation Center's Name) to:

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

Client's Name:_____ Phone:_____
Address:_____
In the event I cannot be reached, contact:_____ Phone:_____
contact:_____ Phone:_____
Physician's Name:_____
Preferred Medical Facility:_____
Health Insurance Co.:_____ Policy #:_____

Consent Plan

This authorization includes x-rays, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Date:_____ Consent Signature:_____
Print Name:_____ Phone:_____
Address:_____

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 whole being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____
_____
_____
_____

Date:_____ Consent Signature:_____
Print Name:_____ Phone:_____
Address:_____