Returning Participant

Application Packet

1285 Brotherton Drive
Cookeville, TN 38506
931.349.8106

Annual Update/Verification of Participant Information

In order for the participant application to be renewed, this form must be returned along with the medical form filled out ENTIRELY, and signed by a doctor.

Participant Name (First/Middle/Last): _____ DOB: ___ / ___ / _____ Weight: _____

Parents/Guardians (First/Middle/Last): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (H)_____ (C)_____ (W)_____

Emergency Phone/Contact Name: (____) _____ _____

E-mail: _____
PLEASE PRING E-MAIL CLEARLY! WE NEED TO UPDATE OUR RECORDS.

PHOTO RELEASE:

I, give permission to Manna's Hana Riding Center, Inc. to use without limitation or obligation, photographs, film footage or tape recordings that may include my family or my child's image or voice for purpose or interpreting Manna's Hana programs.

- ☐ YES
- ☐ NO

PHONE LIST

Participants may need to be notified by phone about upcoming events or schedule changes. We may have a parent assisting the volunteer coordinator make these calls. Indicate if you would like to be notified.

- ☐ YES
- ☐ NO

As you know, in order to offer a quality program like this, we require a lot of volunteers. We require parent/families volunteer while Participants participate as well as assisting with special events/committees. Your signature state you have read the requirements and consent to volunteering and signing up to a committee in order to help Manna's Hana program.

I have reviewed the information above and certify this information is true and correct.

Parent/Guardian Signature: _____ Date: _____

PARTICIPANT'S AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT:

In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving services or while being on the property of Manna's Hana Riding Center, Inc., I authorize The Manna's Hana Riding Center, Inc. to:

- Secure and retain medical treatment and transportation if needed;
- Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment.

Participant Name (First/Middle/Last): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____

General Physician's Name: _____

Preferred Medical Facility: _____

Health Insurance Company: _____

Health Insurance Policy Number: _____

CONSENT PLAN:

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will be invoked only if I am incapacitated and unable to provide direction or, if I am not on the premises at the time, and cannot be reached.

Signature: _____ Date: _____
[Participant, Parent or Legal Guardian]

Parents/Guardians (PRINT NAME): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (H)_____ (C)_____ (W)_____

NON-CONSENT PLAN:

I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while being on the property utilized by MHRC. In the event emergency medical aid/treatment is required, I wish the following procedure to take place: _____.

Signature: _____ Date: _____
[Participant, Parent or Legal Guardian]

Parents/Guardians (PRINT NAME): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (H)_____ (C)_____ (W)_____

PHYSICIAN'S LETTER:

NOTE: ***Send this letter, in addition to the following 3 pages to your General Physician.***

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present and to what degree.

NEUROLOGICAL	COMMENTS	ORTHOPEDIC	COMMENTS
Chiari II Malformation		Atlanto-Axial Instabilities	
Hydrocephalus/shunt		Coxas Arthrosis	
Hydromyelia		Cranial Deficits	
Paralysis due to Spinal Cord Injury		Heterotopic Ossification	
Seizure Disorders		Hip Subluxation/ Dislocation	
Spina Bifida		Internal Spinal Stabilization Devices	
Tethered Cord		Kyphosis	
		Lordosis	
MEDICAL/SURGICAL		Osteoporosis	
Allergies		Pathological Fractures	
Cancer		Scoliosis	
Diabetes		Spinal Fusion	
Hemophilia		Spinal Instabilities/Abnormalities	
Hypertension		Spinal Orthoses	
Peripheral Vascular Disease			
Poor Endurance		SECONDARY CONCERNS	
Recent Surgery		Acute Exacerbation of Chronic Disorders	
Serious Heart Condition		Age Two-Four Years	
Stroke		Behavior Problems	
Varicose Veins		Weight Exceeds 160 lbs.	

If the participant has Down syndrome, and additional Atlanto-Axial x-ray form is required each year.

PHYSICAN'S VERIFICATION

In my opinion, this person can receive riding instructions under proper supervision.

Rider's Name: _____

Physician's Printed Name: _____ Phone: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

Physician's Signature: _____ Date: _____

PHYSICIAN STATEMENT & MEDICAL HISTORY:

NOTE: This section MUST be filled out by your child's General Physician.

Participant Name (First/Middle/Last):
_____

DOB: _____ / _____ / _____ Age: _____ Height: _____ Weight: _____ lbs. Gender: M / F

Address: _____

City: _____ State: _____ Zip Code: _____

Diagnosis: _____ Date of Onset: _____

Date of last Tetanus Shot: _____ Past/Prospective Surgeries: _____
Medications: _____

Seizure Type: _____ Controlled: Y / N Date of Last Seizure: _____

Shunt Present: Y / N Date of last revision: _____

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

Braces/Assistive Devices: _____

For those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result: + / -

Neurologic Symptoms of Atlanto Axial Instability: _____

Please indicate current or past special needs in the following areas, including surgeries:

AREA	YES	NO	COMMENTS
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Emotional/Mental Health			
Behavioral			
Bone/Joint			
Learning Disability			
Independent Ambulation			
Crutches			
Wheelchair			
Other			

PART TWO: RIDER RESTRICTIONS

THE FOLLOWING CONDITIONS MAY BE CONTRAINDICATED (DR.'S RELEASE REQUIRED):

- □ Osteoporosis
- □ Osteogenesis Imperfecta, lordosis, or kyphosis
- □ Recent surgeries
- □ Recurrent pathological fractures
- □ Spina Bifida
- □ Spinal fusions / spinal instability/ spinal stabilization devices
- □ Varicose veins
- □ Diabetes

THE FOLLOWING CONDITIONS ARE CONTRAINDICATED (UNADVISABLE) FOR THERAPEUTIC RIDING:

- □ Structural scoliosis greater than 30 degrees
- □ Uncontrolled seizures
- □ Positive X-Ray for Atlantoaxial Instability (see additional information)
- □ Tethered Cord or Chiari II Malformation
- □ Hip subluxation, dislocation, or degeneration
- □ Indwelling catheter
- □ Spinal Cord Injury above a T-6
- □ Hemophilia

PRECAUTION: MONITOR FOR NEUROLOGICAL SYMPTOMS, REPORT CHANGES TO THE FAMILY PHYSICIAN.

**Contraindications – not recommended for therapeutic riding:
Children under the age of 4 (Dr/OT/PT recommended before considering)
Neurological symptoms Atlantoaxial instability (see above)
Positive neurological clinical signs as noted by the physician
Significant ADI measurement as determined by the physician

RECOMMENDS THAT ALL PARTICIPANTS WITH DOWN SYNDROME HAVE:

Prior to starting mounted activities:
A medical examination with special reference to neurological function
Initial lateral or side view X-Rays, within the past 2 years, of the upper cervical region in:

1. Full flexion
2. Extension

Certification by a physician that an examination did not reveal Atlantoaxial instability or focal neurological disorder

WITH CONTINUATION OF MOUNTED ACTIVITIES:

Annual certification from a physician that the participant's annual physical examination reveals no symptoms of AAI.
Following the initial X-ray, indication for repeated X-Rays should be made at the discretion of the participant's physician.

Atlantoaxial Instability Symptoms:

Change of Head Control	Change in Hand Control
Torticollis	Progressive weakness
Head tilt	Fisting
Stiff neck	Change of dominant hand
Change in gait	Increasing tremor
Progressive clumsiness	Change in Bladder Function
Toe walking or scissoring	Change in Bowel Function
Falling	Posturing

PRESCRIPTION & MEDICAL TEAM CONSENT:

NOTE: This section MUST be filled out by your child's General Physician, AND signed off on by your child's alternate medical professionals including, but not limited to: PT, OT, Orthopedic Surgeon, and others.

**You do not need additional sign-off if your child does NOT currently see any specialists beyond a General Physician.*

ADDITIONAL MEDICAL PROFESSIONAL #1

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that the Riding Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Riding Center for ongoing evaluation to determine eligibility for participation.

Name: _____ MD / DO / NP / PA / Other: _____

Signature: _____ Date: _____

Address: _____

Phone: (_____) _____ License/UPIN Number: _____

ADDITIONAL MEDICAL PROFESSIONAL #2 *(Conducted at Participant's School)*

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that the Riding Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the Riding Center for ongoing evaluation to determine eligibility for participation.

Name: _____ MD / DO / NP / PA / Other: _____

Signature: _____ Date: _____

Address: _____

Phone: (_____) _____ License/UPIN Number: _____

PARENT AGREEMENT TO NOTIFY FORM:

I agree to notify Manna's Hana Riding Center, Inc. in writing in the event that I/my son/daughter/ward is unable to ride, for any period of time during the course of the Program Year, due to:

- MEDICAL PROCEDURES
- IILLNESS
- INJURY
- OTHER INCIDENTS THAT MAY AFFECT THE PARTICIPANT'S ABILITY TO SAFELY BE ON A HORSE.

Participant's Name: _____

PARENT/GUARDIAN:

Print Name: _____

Signature: _____ Date: _____
[Participant, Parent or Legal Guardian]

PARENT/GUARDIAN:

Print Name: _____

Signature: _____ Date: _____
[Participant, Parent or Legal Guardian]

I have read and understand the new changes listed below to Manna's Hana Riding Center relating my child/myself riding at the center.

Name: _____ Date: _____
(Signature)

(Parents/Participant Keep this sheet)

Please note the following changes to Manna's Hana Riding Center:

1) Applications are due two weeks before the session begins.
2) Late applications received before the session begins will result in the participant riding at a later date. The participant will then be notified when they are eligible to ride.
3) **If participant arrives 15 minutes late, they will not be able to ride that day.** This is counted as an unexcused absence.
4) **Payment for the session is expected regardless of absences and no-shows.**
5) If the participant is unable to ride call the office at 931-537-6322 or 931-349-8106 *as soon as possible*; if no answer, PLEASE leave a detailed message. Our volunteers and instructors drive the distance and fight the traffic as you do in order to help. By letting us know the participant will be absent, we can let our volunteers know so that they can plan their day.
6) Illnesses **not** requiring hospitalization to be considered excused with a doctor's note.
7) Illnesses requiring hospitalization or other unforeseen emergencies, please notify the riding center asap.
8) Two unexcused absences or a no-shows during a session (8 weeks) will disqualify the participant from the remainder of the session and the participant will be placed on the waiting list for the next available session.
9) Scholarship Participant with one (1) no-show or unexcused absence will become ineligible for future scholarships.
10) If Manna's Hana must cancel a class due to weather or other circumstances, the participant will receive a credit for the canceled class toward the next session.
11) If the participant will be out of town during the riding session, please speak with Bobbie at the beginning of the session. These absences will be considered advanced and the participant will not be expected to pay for one missed lesson during a session. However, if the participant fails to inform the office of this information in advance the participant will be charged. (Example: letting Bobbie or an instructor know the participant won't be coming the next week because they are going camping, on vacation. This is considered an unexcused absence and will require payment for the missed lesson.)
12) Manna's Hana is dedicated to provide an environment for our participant's to grow.

Please return the completed application with participant's payment two weeks before the start of the session to:

Manna's Hana Riding Center
1285 Brotherton Drive
Cookeville, TN 38506

DON'T BE A "NO-SHOW, NO-CALL" THIS RESULTS IN:

Unnecessary tacking and untacking of our horses
Inefficient use of staff and volunteers
Excessive absences take up a time slot that could be used by another rider
Loss of scholarship for future sessions