Reins in Motion Foundation

Welcome

Thank you for your interest in therapeutic riding. Enclosed is a packet of information and forms, which must be filled out and returned to us, including session payment, at the start of each session.

Reins in Motion Foundation is a non-profit therapeutic horseback riding program, which creates a supportive and dynamic environment for the development of disabled children and adults and those with life threatening illnesses living in the Bay Area. Through the use of the horse, physical, psychological, cognitive, behavioral, and communicational goals are achieved and personal strengths are emphasized.

Our students are challenged with various conditions including cerebral palsy, autism, downs and other spectrum disorders, paraplegia, sight, hearing deficit, life threatening illnesses, spinal issues that are recommended by a PT, OT and neurologists, and developmental and learning disabilities. Their ages range from preschool into adulthood.

Physicians, therapists, teachers and friends refer students to the Center. Reins in Motion PATH Certified Instructors design individual lesson plans for each client tailored to their ability level. Through a variety of horse related activities, our riders gain greater confidence, self-awareness, increased balance, muscle strength and self-esteem.

For more specific information on these programs and for our current schedule contact RIMF at 925-518-7558 or email info@reinsinmotionca.com

Thank you!

Reins in Motion Staff

Program address: 9300 Tesla Road, Livermore, CA 94551

Mailing address: PO Box 1001, Livermore, CA 94551

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Program

Lessons are a minimum of 30 minutes up to 1 hour. Client's stability will determine the number of volunteers to assist with lesson. Lessons will be held rain or shine. We will make every effort to make client comfortable. On days when it is either too rainy or too hot, ground classes may take the place of riding. We will work on grooming skills, sensory activities, the learning of horse body parts and or large or small motor skills activities.

Fees

Please refer to contract/agreement for Session Fees and Terms and Conditions.

Attire

RIMF provides approved safety helmets and students are required to wear them while mounted or when working around the horses.

Please wear appropriate closed toed shoes at all times. If your child or client comes in sandals they WILL NOT RIDE. Boots are preferable because of heel and leather sole. Closed toed tennis shoes will be allowed. No clogs or sandals of any kind.

Long pants are important for those that are riding independently. Preschoolers who ride on the bareback pad may wear shorts in warmer weather.

Dress for comfort and according to weather. Use of sunscreen, sunglasses and water in warm weather and layers and gloves in cooler weather. RIMF has a bin of gloves available if needed.tudentn

Volunteers

We have very committed volunteers that help with lessons, horse care, and many other responsibilities to ensure that we can run our program safely and keep our lessons to the highest quality possible. If you know of anyone who would like to volunteer, there are many ways that we could use their help. Please contact RIMF by phone or email, and will be in touch with them.

Safety Rules

Do not leave your child or other children unattended or allow them to run around or play loudly. These behaviors could startle the horses or upset other clients.

Please do not visit or touch other horses in the barn as they are not ours. With permission, you may say hello to RIMF horses.

You and your family members are always encouraged to stay and watch lesson but in doing so, please keep in mind that for the riders safety, quiet and calmness is a must.

Weight

There is a weight restriction for all clientele. Our insurance will not allow us to take any riders over 200lbs. This is for the safety of the horses and volunteers on the ground. Other alternative services may be considered such as cart riding.

Attitude and Behavior

Students must demonstrate a personal desire for participation in the program. Students will demonstrate a respectful attitude toward instructors, fellow students, volunteers, parents, horses and other animals at all times. Students will comply with all barn rules, policies and exercise good judgment to ensure the general safety of all persons and animals present.

Attendance

Students should arrive a few minutes before their scheduled lesson so they have time to get their helmet and be ready to ride on time. Should you be running behind, please call your specific instructor to let them know. Instructor phone numbers are listed on the contract/agreement.

Program Support

RIMF is a non-profit foundation that is supported mainly by volunteer staff. We rely on grants, donations and horse sponsorships to keep the program going and to help keep our client cost down. As such, we request help now and then to help support our program. This may be asking for help with an upcoming fundraiser, looking for sponsorship, etc. Thank you so much for all of your support !

Possible Reasons for Client Discharge

1. Participant's inability to maintain head and neck control while sitting on the horse presents a safety concern.

2. Inability to follow directions that interferes with progress toward treatment goals.

3. Uncontrolled or inappropriate behavior that causes a safety risk for either the participant, instructor, volunteer, or horse.

4. Participant's weight exceeds 200 lbs.

5. Changes in medical, physical, cognitive or emotional condition that makes therapeutic riding inappropriate.

6. Nonpayment of session fees. (see contract for fees)

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Participant Application and Health History

GENERAL INFORMATION

Participant:_____
_____

DOB _____ Age:_____ Height _____ Weight:_____

Gender: M F

Address:_____
_____

Phone:_____ Email:_____

Alternate phone:_____

Employer/School:_____

Parent/Legal
Guardian:_____

Address if different from
above:_____

Phone:_____

Referral
Source:_____

HEALTH HISTORY

Diagnosis_____

Date of Onset:_____ Please indicate current or past special needs in the following areas:

Vision: Y____ N_____
Comments:_____

Hearing: Y_____ N_____
Comments:_____

Sensations: Y___ N____
Comments:_____

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Communications: Y___ N_____
Comments:_____

Heart: Y___ N_____
Comments:_____

Breathing: Y___ N____
Comments:_____

Digestion: Y___ N____
Comments:_____

Elimination: Y___ N___
Comments:_____

Circulation: Y___ N___
Comments:_____

Emotional/Mental Health: Y____ N____
Comments:_____

Behavioral: Y___ N____
Comments:_____

Pain: Y_____ N_____
Comments:_____

Bone/Joint: Y____ N_____
Comments:_____

Muscular: Y____ N_____
Comments:_____

Thinking/Cognitive: Y___ N___
Comments:_____

Allergies: Y____ N_____
Comments:_____

What medications is participant currently taking, including over the counter medications?
_____

_____

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Describe participants abilities/difficulties in the following area (include assistance required or equipment needed) FUNCTION (i.e. mobility skills such as transfer, walking, wheelchair use, driving / bus riding:

_____
_____
_____

SOCIAL (i.e. work/school including grade completed, leisure interests, relationships-family, support systems, companion animals,
fears/concerns)_____
_____
_____
_____

_____
_____ GOALS
(i.e. why you are applying for participation and what would you like to accomplish):

_____

_____
PHOTO RELEASE

One of the best ways to explain our mission of supporting children is through photographs, video, artwork, and testimonials of our program participants. We use these in our brochures, newsletters, website, and social media. I agree that photographs taken of Participant or other materials created by Participant and submitted to Reins in Motion, shall become property of and may be used by Reins in Motion, at its discretion, for any publicity or marketing purposes, and I hereby consent and authorize such use without restriction.

I DO_____ authorize

DO NOT_____ authorize

Signature:_____Date:_____

Participant, Parent or Legal Guardian

Page 7A Physician'sStatement (Page 1 of 3) – *must be signed by physician*

Student:_____

DOB:_____ Age:_____ Height:_____ Weight:_____ Male Female

Address:_____

Diagnosis:_____ Date of Onset:_____

Past/Prospective Surgeries:_____

Medications:_____

Seizure Type:_____ Controlled: Y N Date of Onset:_____

Shunt Present: Y N Date of Last Revision:_____

Special Precautions/Needs::_____

_____

Mobility: ☐ Independent Ambulation ☐ Assisted Ambulation ☐ Wheelchair

Braces/Assistive Devices:_____

For those with Down Syndrome: AtlantoDens Interval X-rays - Date:_____ Result: ☐ positive ☐ negative

Neurologic Symptoms of AtlatoAxial Instability:_____

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

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

Signature:_____ Date:_____

Address:_____

Phone:_____ License/UPIN:_____

PLEASE CAREFULLY READ PRECAUTIONS AND CONTRAINDICATIONS ON REVERSE

Physicians Statement Page 7B

Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability – include neurologic symptoms

Coxa ArthrosisCranial Deficits

Heterotopic Ossification/Myositis Ossificans

Joint subluxation/dislocation

Osteoporosis

Pathologic Fractures

Spinal Fusion/Fixation

Spinal Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt

Seizure

Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia

Medical/Psychological

Allergies

Animal Abuse

Physical/Sexual/Emotional Abuse

Blood Pressure Control

Dangerous to self or others

Physicians Statement Page 7C

Exacerbations of medical conditions

Fire Settings

Heart Conditions

Hemophilia

Medical Instability

Migraines

PVD

Respiratory Compromise

Recent Surgeries

Substance Abuse

Thought Control Disorders

Weight Control Disorder

Other

Age – under 4 years

Indwelling Catheters

Medications – i.e., photosensitivity

Poor Endurance

Skin Breakdown

Reins in Motion Foundation Riding Program Creed

WE believe dreams are essential to life and right to risk belongs to us all.

WE commit ourselves to slaying the dragons of doubt in ourselves and others.

WE believe the world is changed one life and one step at a time.

WE believe persons with disabilities should be in control of their own lives.

WE dedicate ourselves to a program designed for the individual, wherein quality will always be placed before quantity.

WE pledge ourselves to a program where disabled people govern themselves and a learning model based on mentorship.

WE believe freedom and dignity are priceless; success can only be kept when given away.

WE believe life is a Round Table where in each member is both student and teacher.

WE pledge to build in each other virtues of Courage, Loyalty, Compassion, Honor, Justice, Generosity and Faith.

WE believe in the philosophy of ENN, which calls on each of us to rise to our highest good and goals.

WE dedicate ourselves to quality life with programs that offer opportunities to Dream, to risk, to love and to serve.

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Reins in Motion Foundation Informed Consent Release of Liability

Name (participant)
_____

Address
_____

City, State, Zip
_____

Age at date of session
_____

Name of guardian (if participant is a minor)_____

If the above-listed Participant is under 18 years of age, I hereby declare that I am authorized as their guardian to sign this Legal Release on their behalf, and understand and agree that they are bound by all terms and conditions of this document.

In consideration of the services provided by Reins in Motion Foundation (RIM) & their respective agents, employees, directors, officers, contractors, volunteers, in connection with Participant's participation at Reins in Motion, I as Participant or, if Participant is a minor, as parent/guardian of Participant agree as follows:

I am familiar with the Program and all of my questions about the Program, including questions concerning the details of activities, the physical conditions, and the Program's location have been answered to my satisfaction. I understand that participation in the Program creates a risk of injury and I expressly acknowledge and assume the risk of such injury to the Participant. The following describes some of those risks.

- The Program involves outdoor activities where exposure to environmental risks include poison oak, insects, snakes, predators, unpredictable forces of nature such as storms, earthquakes, and wildfires. Entering restricted areas on the property is prohibited and could be dangerous.

- The Program may require travel to an off-site activity by bus or vehicle and includes: horseback riding. Possible injuries include sunburn, dehydration, heat stroke, slipping, falling, drowning, and other mild or serious injuries and conditions.

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- An environment free of allergens, including but not limited to food allergens, cannot be guaranteed at Reins in Motion. Therefore, RIM cannot guarantee the Participant will not come into contact with any allergens while at Reins in Motion. Participation in the program will expose the participant to food, activities and persons that may result in exposure to allergens and injury.

I agree that this description of risks is not complete, and that unknown or unanticipated risks may result in property loss, injury, or death. I understand that the unique character of this Program is to serve participants who are medically fragile or high risk. I have submitted, to the best of my knowledge, complete health history information to the ENN and represent that Participant is free from medical or physical conditions that might create undue risk to Participant. I represent that Participant is fully capable of participating in this Program. Therefore, I assume and accept full responsibility for any injury, death, loss of personal property, and/or expenses that may result from Participant's involvement in this Program, and I further agree to indemnify and hold harmless Exceptional Needs Network and their agents, employees, directors, officers, contractors, volunteers, and all entities associated with it to the fullest extent of the law, from any and all damages, losses or liability that may result from Participant's involvement in the Program.

Participant Signature (if age 18 or older) _____ **Date**: _____

Parent/Guardian Signature _____ **Date:** _____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Print Participant Name _____ Date of Birth _____

Print Parent/Guardian Name (if applicable) _____
Address _____

City _____State_____ Zip _____
Hm.Ph._____Wk.Ph_____Cell_____

In the Event I cannot be reached:

Contact_____ Phone_____
Alternate Contact _____ Phone_____
Physician's Name _____ Phone_____
Preferred Medical Facility_____ Phone_____

Health Ins.Co._____ _____ List all pertinent medical information (allergies to food or drugs, medications being taken, special medical condition _____

CONSENT PLAN

In the event of an emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or working in program or while being on the property of the agency, I authorize Reins in Motion Foundation to:

1.) Secure and retain medical treatment and transportation if needed.

2.) Release client records upon request to the authorized individual or agency

Date _____ CONSENT SIGNATURE_____

Print Name and Relationship_____

NONCONSENT PLAN

I do not give my consent for emergency medical treatment in the case of illness or injury during the process of receiving services, working in program or while being on the property of RIMF In the event of emergency treatment/aid is required I wish the following procedures to take place:

Date: _____NONCONSENT SIGNATURE_____

Name and Relationship:_____