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| **2023 S.T.A.R.S. Rider Registration Form****(Special Training and Riding Skills)** |

 

 **Please Print**

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| Name: | Date of Birth: | Age: | Sex: |  |
| Address: | City: | State: | Zip: | E-mail address: |
| Rider’s Support Person(s): (Parent, Staff) | Relationship to the Rider: |
| Support Person Address:Preferred contact #: | City: | State: | Zip: | E-mail address: |
| How did you hear of the S.T.A.R.S. Program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property where S.T.A.R.S. is conducted, I authorize S.T.A.R.S. staff 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. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**What is the goal for the rider? (Example: core strength, confidence, balance, self-esteem, social outing, bonding with the horses, laps, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Long pants must be worn, no shorts allowed. Riding boots are preferred for safety. At the minimum, closed toe and enclosed heels are mandatory.

Intent to disrupt, harm, or harass staff, volunteers, or horses will not be tolerated. The individual will be asked to leave and no refund will be issued.

If the participant is not feeling well, please do not have them attend.

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| **Liability Release**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ would like to participate in the S.T.A.R.S. program. I acknowledge the risks and potential for risks of a horseback riding program. However, I feel that the possible benefits to myself are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assignees, executors, or administrators, waive and release forever all claims for damages against S.T.A.R.S., its board of directors, instructors, therapists, volunteers and/or employees for all injuries and/or losses I may sustain while participating in S.T.A.R.S.Signature of parent/guardian or adult rider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**WARNING:** Under South Dakota law, and equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to 42-11-2. |

**Participant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Page 2**

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| **Photo and Publicity Release**I hereby consent to and authorize the use and reproduction by S.T.A.R.S. of all photographs and any other audio/visual materialstaken of the participating rider for promotional printed materials, social media, educational activities, exhibitions, or any other use for the benefit of the program.Signature of parent/guardian or adult rider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| **Policies and Payments:** *Please initial next to each statement below to indicate we have communicated clearly.*\_\_\_\_\_ Riders must attend each session with a parent, guardian, or support person who understands well the nature of any  disability or chronic illness and who is authorized to make decisions regarding the rider’s health and safety.\_\_\_\_\_ It is expected that riders arrive on time, appropriately dressed wearing long pants and closed heel and toe shoes.\_\_\_\_\_ In order to facilitate S.T.A.R.S., we count on several volunteers that commit their time and energy to make this program  possible. Please notify S.T.A.R.S. 24 hours in advance if a rider will be absent. In case of last-minute emergency, please  notify S.T.A.R.S. as soon as possible.\_\_\_\_\_ The fee for each Session is $55.00. There is a discount for multiple-family members participating (2 family members for  $90.00). All payments are non-refundable.\_\_\_\_\_ Balance is due with this registration from. Scholarship assistance is available. If you need scholarship assistance, please  call (605) 690-0259 or email S.T.A.R.S. Program Director, Kristine Skorseth, (brookingsstars.director@gmail.com) to  request a scholarship. |
| **Session Choice:** (Mark as many as you wish to participate in.) Please mark your preference for riding time. (1 for first choice and 2 for second choice) **Please Note: Due to unpredictable spring weather, we may need to adjust the session schedule. We will be in contact.** \_\_\_\_\_ Session #1, Ride #1 $55 **May 30,** **June 1, 6, 8, 13, 15, 20, 22 5:30-6:30 PM** \_\_\_\_\_ Session #1, Ride #2 $55 **May 30,** **June 1, 6, 8, 13, 15, 20, 22 6:30-7:30 PM**  **Make up rides June 27 and 29 due to weather cancellations** \_\_\_\_\_ Session #2, Ride #1 $55 **July 11, 13, 18, 20, 25, 27, August 1, 3 5:30–6:30 PM** \_\_\_\_\_ Session #2, Ride #2 $55 **July 12, 14, 19, 21, 26, 28, August 2, 4 6:30-7:30 PM** **Make up rides August 8 and 10 due to weather cancellations** \_\_\_\_\_ Session #3, Ride #1 $55 **August 15, 17, 22, 24 ,29, 31 September 5, 7 5:30-6:30 PM** \_\_\_\_\_ Session #3, Ride #2 $55 **August 15, 17, 22, 24 ,29, 31 September 5, 7 6:30-7:30 PM** **Make up rides September 12 and 14 due to weather cancellations****T-Shirt Size: \_\_\_\_\_\_ Child’s Sm \_\_\_\_\_\_ Child’s Med \_\_\_\_\_\_ Child’s Lg \_\_\_\_\_\_ Sm \_\_\_\_ Med \_\_\_\_\_\_ Lg**  **\_\_\_\_\_\_ XLg \_\_\_\_\_\_ 2XLg \_\_\_\_\_\_ 3XLg** **To help defray the registration fee, contact Kristine for agencies/organizations that may be able to help with** **the registration fee.**   |
|  Page 3**Consent for Release of Information** I hereby authorize: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Person or Facility)to release health information from the records of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Participant’s Name)The information is to be released to S.T.A.R.S. (Special Training and Riding Skills) for the purpose of developing a Therapeutic Riding Program for the above-named client. The information to be released is marked below.\_\_\_\_ Medical History \_\_\_\_ Physical Therapy evaluation, assessment, and program plan \_\_\_\_ Classroom Individual Education Plan \_\_\_\_ Occupational Therapy evaluation, assessment, and program plan\_\_\_\_ Speech Therapy evaluation, assessment, and program planSignature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Please send the indicated material to Program Director)**Information for Physician**

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

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| **Orthopedic**Spinal Fusion Scoliosis Kyphosis Lordosis Osteoporosis Coxa Vara Cranial Deficits Spinal Deficits Heterotrophic OssificationOsteogenesis ImperfectaInternal Spinal Stabilization DevicesSpinal instabilities/abnormalitiesPathologic FracturesAtlantoaxial InstabilitiesHip Subluxation and Dislocation**Neurologic**Hydrocephalus/shuntHydromyeliaTethered cordSpina BifidaChiari II MalformationSeizure DisorderParalysis due to Spinal Cord Injury **Notes:** | **Medical/Surgical**Poor Endurance Recent Surgery Varicose Veins Hemophilia HypertensionPeripheral Vascular DiseaseSerious Heart ConditionStroke (Cerebrovascular Accident)AllergiesCancerDiabetes**Secondary Concerns**Behavior problemsAge under two yearsAge two-four yearsAcute exacerbation of chronic disorderIndwelling Catheter  |  |  |

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**Participant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_**   Page 4**Name of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Rider’s Medical History and Physician’s Statement****(To be completed annually)****Please Note: S.T.A.R.S. will accept a current health statement from a Special Olympics application. You do not need to get another health statement for S.T.A.R.S. Please attach your Special Olympics health statement to this form.**

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| --- | --- | --- |
| Diagnosis:  | Date of Birth: | Weight: |
|  |  |

**Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment. Circle Yes/No**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Area** |  |  |  | **Comments** | **Area** |  |  | **Comments** |
| Auditory | **Yes** |  | **No** |  | Muscular | **Yes**  | **No** |  |
| Visual | **Yes** |  **No**  |  |  | Orthopedic | **Yes**  | **No** |  |
| Speech | **Yes** |  **No** |  |  | Allergies | **Yes** | **No** |  |
| Cardiac | **Yes** |  **No** |  |  | Learning Disability | **Yes** | **No** |  |
| Circulatory | **Yes**  |  **No** |  |  | Mental Impairment | **Yes** | **No** |  |
| Pulmonary | **Yes**  |  **No** |  |  | Psychological Impairment | **Yes** | **No** |  |
| Neurological | **Yes**  |  **No** |  |  | Other | **Yes** | **No** |  |
| **Mobility** |  | Independent Ambulation Yes No | Crutches Yes No | Braces Yes No | Wheelchair Yes No |

Additional Notes:**Participant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Page 5To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding program will weigh the medical information above against the existing precautions and contradictions. I concur with a review of this person’s abilities/limitations by a licensed/credentialed health professional (PT, OT, Speech Therapist, Psychologist, etc.) in the implementing of an effective program.

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| Physician Name: (Please Print) | Phone #: |
| Physician Signature: | Date: |
| Physician’s Address: (Include City, State, Zip) |

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Please return Registration and Health Forms to:

STARS Program Director

Kristine Skorseth

3413 Co Hwy 1

Hendricks, MN 56136

OR

You may drop off at

3405 6th St., Ste. 4

Brookings, SD 57006

Brookingsstars.director@gmail.com

605-690-0259