2025 S.T.A.R.S. RIDER APPLICATION
Adaptive Riding for People with Disabilities

OFFICE USE Session 1 – 2 – 3
Time 5:30 – 6:00 – 6:30 – 7:00
◯T-shirt Received

Rider's Name:	Date of Birth:	Sex:
Address:	City, State, Zip:	
Phone:	Rider Email:	
Rider's Support Person:	Relationship to Rider:	
Support Phone:	Support Email:	

How did you hear about STARS?

What are your goals as rider? (check all that apply)
___Improve core strength ___improve motor skills ___social outing w/people ___social w/horses
___Increase confidence ___Encourage/improve communication ___Learning horse skills
___Other (explain):

Military veteran? ___Yes ___No
If yes, branch of service: Military Disability Rating:

Medical Release

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while on the property where STARS is conducted, I authorize STARS staff to (1) secure and retain medical treatment and transportation if needed; (2) release client records upon request to the individual or agency involved in the medical emergency treatment.

Signed *(Parent, guardian or adult rider)* _____ Date _____

Photo and Publicity Release

I hereby consent to and authorize the use and reproduction by STARS of all photographs and other audio/visual materials taken of the participating rider for promotional material including printed, social media, website, exhibitions, fundraising and educational activities, grant applications or any other use for the benefit of the program.

Signed *(Parent, guardian or adult rider)* _____ Date _____

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.

Signed *(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.

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Rider Name:_____

Session Choice: Select session(s) you wish to participate in and then mark your 1st and 2nd choice for riding times desired. Space is limited & ride times are not guaranteed. Please note if you would like to participate in more than 1 session; priority will go to make sure everyone gets at least one session before additional rides will be scheduled.

☐ **Session #1** $80 **June 5, 10, 12, 17, 19, 24, 26, July 1**

_____ 5:30-6:00
_____ 6:00-6:30
_____ 6:30-7:00
_____7:00-7:30

☐ **Session #2** $80 **July 8, 10, 15, 17, 22, 24**

_____ 5:30-6:00
_____ 6:00-6:30
_____ 6:30-7:00
_____7:00-7:30

This session features 6 sessions with the goal of more horse interaction time for each rider. Number of participants is limited.

☐ **Session #3** $80 **August 5, 7, 12, 14, 19, 21, 26, 28**

_____ 5:30-6:00
_____ 6:00-6:30
_____ 6:30-7:00
_____7:00-7:30

Would you like to be scheduled with another particular rider? If so, please list here: _____

Select Rider T-Shirt Size: _____ No shirt _____ Child's Sm _____ Child's Med _____ Child's Lg
_____Adult Sm _____ Adult Med _____Adult Lg _____Adult XLg _____ 2XLg _____ 3XLg

POLICIES & PAYMENT:

Please initial next to each statement below to indicate we have communicated clearly.

_____ Riders must be accompanied by a parent, guardian, or support person who understands well the nature of any disability or condition 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, closed heel and toe shoes with socks. Boots may be available for loan. Rider's MUST wear a helmet at all times around the horses; helmets will be provided by STARS. Late arrival may increase wait time.

_____ The fee for each Session is $80.00. There is a discount for multiple-family members participating (2 family members for $120.00). All payments are non-refundable. Due to unpredictability of weather, number of rides is not guaranteed. Cancellations may occur due to rain or extreme heat and no refunds will be made for such interruptions. Cancellations will be announced via phone call or text, as well as listed on Facebook. Cancellations are typically made by 4:30pm on ride nights unless a session is unexpectedly interrupted by rain.

_____ Balance is due with this registration from. Financial assistance may be available through Family Support Services. Please email S.T.A.R.S. Director at brookingsstars.director@gmail.com with any financial questions

REGISTRATION MUST BE RECEIVED BY MAY 1st, 2025.

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HEALTH HISTORY

Rider's Name:	Date of Birth: Age:
Height:	Weight:
Please list all diagnoses or disabilities including year of onset:	

Has the participant ever been treated for any of the following? If yes, provide details.

Check if yes	Condition	Date onset	Details
	Down syndrome		
	Spinal condition, i.e. injury, scoliosis, fusion, Spina Bifada, etc		
	Brain condition, i.e. Cerebral Palsy, stroke		
	Bleeding or clotting disorders		
	Diabetes		
	Joint complications, i.e. hip dysplasia, etc		
	Epilepsy		Date of most recent seizure:
	Heart condition including pacemakers		
	Neurological condition, i.e. hydrocephalous, mitochondrial disorder, etc		
	Pulmonary condition		
	Skin break down or pressure sores		
	Medical shunt or any type of feeding tube		

In the past 12 months, has the participant experienced:

Check if yes		Check if yes	
	Loss of consciousness, including seizures		Assistance to maintain an upright sitting position or control of the head
	Hospitalization for mental health crisis		Hospitalization for serious injury, condition, surgery
	Activity restrictions due to medical reasons		Any seizure activity for any reason Date of last seizure: Cause of seizure:
	Medical device such as an insulin pump, catheter or colostomy bag?		

<u>If yes to any of the above, please provide date and details and submit Physician's Release (page 5)</u>

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Riders Name:		
General Health & Function Has rider ever been treated for the following? If yes, please explain in detail		
	Check if yes	Details
Hearing		
Vision		
Speech		
Immune deficiency		
Circulation		
Cognitive development		
Pulmonary		
Fatigue or limited endurance		
Muscular		
Orthopedic (including spine & joints)		
Emotional, psychological, PTSD		
Behavior		
Broken bones		
Other		
Allergies		
Does the rider use the following:		
Walker		
Crutches		
Wheelchair		
Body brace of any type		
EpiPen		
Inhaler		
Please describe what any typical seizure or allergic reaction looks like for rider and how it is best treated or managed on-site		

STARS may request additional information prior to or during the course of STARS sessions, or restrict or offer alternative activities as conditions and abilities warrant.

Name of person completing form:_____

Relationship to rider: _____

Signature:_____ Date:_____

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PHYSICIAN'S RELEASE

Riders Name:	**Date of Birth:**
Parent/Guardian:	**Phone:**

This form is required if rider has Down Syndrome or any seizure activity.
This form is required if any HEALTH QUESTIONS on page 3 were answered YES.

GENERAL	**Normal**	**Notes/Details**
Appearance & Affect		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Pulses		
Heart		
Lungs		
Abdomen		
Skin		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Upper Extremities		
Lower Extremities		
Allergies		
DOWN SYNDROME		
Does this patient have symptoms consistent with atlantoaxial instability?		
SEIZURE ACTIVITY		
Does this patient require close supervision due to seizure symptoms?		

PHYSICIAN'S RELEASE

I have examined the above-named participant and, given the participant's diagnosis and health history, this person does not present apparent clinical contraindications for equine sports. I understand that S.T.A.R.S. will weigh the medical information provided against existing precautions and contraindications; therefore, I refer this person to S.T.A.R.S. to determine on-going eligibility for the recreational therapeutic riding program.

Physician Name (please print)_____

Physician Signature _____ Date of Exam _____

Physician Clinic _____Physician Phone_____

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Application Deadline May 1, 2025

ADVANCE RIDERS:

Return completed forms to Advance Office

All Other Riders:

Return completed forms to

STARS Program Director
PO Box 974
Brookings, SD 57006

Any questions may be directed to:

Brookingsstars.director@gmail.com

Riders will be contacted regarding confirmed ride schedule about May 15th.