

**TIANVICA RIDING ACADEMY, INC**

**CLIENT HANDBOOK**

**1<sup>ST</sup> EDITION JULY 2008**

**P.O. Box 7301  
LAKELAND, FLORIDA 33811**

**863. 581.7861 or 581.7859**

**[www.tianvica.org](http://www.tianvica.org)**

**Welcome to TiAnViCa Riding Academy, Incorporated.**

We are so glad you are interested in riding with us. TiAnViCa Riding Academy, Inc exists to provide a safe and fun environment for therapeutic riding and to enrich the lives of our riders, volunteers and staff.

Please review our brochure and see our web site at [www.tianvica.org](http://www.tianvica.org) for additional information on our program.

We ask that you read the handbook and fill out the following applications and forms. The first three forms are for you to fill out and sign. They are the *application and health history with photo release*. Next is the *authorization for emergency medical treatment*, and the third is a *liability release*. We also ask that the parent/caregiver who will be accompanying a riding fill out and sign a liability release as well.

The next forms are for you and you medical professionals (physician, therapist, etc). The first in the *introductory letter to your physician*, please place the riders name on the form. Next is the *consent for release of information*. You will need to send this to each health professional you wish to share information with us and check what you wish for them to share with us. The final form is the *participant's medical history & physicians statement* which is to be filled out completely by your physician. You may also refer this form to any other professional you wish to share information with us.

Once we have all these forms returned to us we will schedule an appointment to evaluate the rider and determine if they are appropriate to ride in our program. Safety of our riders, volunteers, staff and horses are our first priority and we will take this into consideration when determining if recreational therapeutic riding at TiAnViCa is appropriate at this time.

Thank you again for your interest in ***"Riding for Therapy."***

Roger Meadows

Executive Director/Instructor

## **Tuition and Fees**

TiAnViCa holds 5-week sessions. The cost for the session is \$150 and is due on week 5 to hold your place in the next session. There will be one make up class each session (see the next section).

There may be additional fees for entrance fees for shows if you are participating.

Sibling discounts are available; please contact us for more information. Discounts are also available for advance payment of multiple sessions.

## **Attendance**

Attendance each week is expected. There is much preparation for each class and we have volunteers that are excited to be working with you. Yet, we understand that the unexpected can happen. If you cannot make a class please notify us as soon as possible, preferably 24 hours in advance. If notice is not received 30 minutes before the scheduled class, no make up class will be offered.

***There will be only one make up class each session on the 6th week.*** If a rider misses more than one class or cannot attend the make up class the rider will forfeit the fee for that class.

If classes are cancelled the rider will use the make up class as the replacement class. If they have missed a second class TiAnViCa will pro-rate the next session.

No refunds will be given.

## **Dress Code**

Due to the nature of equine assisted activities we require that each rider wear appropriate attire. This includes long pants, T-shirt or other appropriate shirt (no tank tops or spaghetti straps), and hard-soled close-toed shoes (preferable boots).

We understand that due to the nature of the individuals' disability this dress code may not be able to be met. We will make accommodations on a case-by-case basis as long as the safety of the rider is not compromised.

TiAnViCa Riding Academy, Inc.  
 PO BOX 7301  
 Lakeland, Florida 33811-7301  
 863.581.7859 or 863.581.7861

## Participant's Application and Health History

### GENERAL INFORMATION

Participant: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: M F

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail \_\_\_\_\_ Alternative #: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Phone: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Phone: \_\_\_\_\_

How did you hear about the program? \_\_\_\_\_

### HEALTH HISTORY

Diagnosis \_\_\_\_\_ Date of Onset: \_\_\_\_\_

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

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

# Participant's Application and Health History

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**MEDICATIONS** (include prescription, over-the-counter; name, dose and frequency) \_\_\_\_\_

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*Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):*

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**PHYSICAL FUNCTION** (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

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**PSYCHO/SOCIAL FUNCTION** (i.e. Work/school including grade completed, leisure interests,

relationships-family structure, support systems, companion animals, fears/concerns, etc)

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**GOALS** (i.e. Why are you applying for participation? What would you like to accomplish?)

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Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Client, Parent or Legal Guardian (Sign and Print Name)

## Photo Release

I consent to and authorize the use and reproduction by TiAnViCa Riding Academy, Inc. of any and all photographs and any other audio-visual materials bearing my image for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Name: \_\_\_\_\_ (print legibly)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For minor or ward: \_\_\_\_\_ (print legibly)

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Name: \_\_\_\_\_

Allergies: \_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Insurance Provider: \_\_\_\_\_ Policy # \_\_\_\_\_

Consent Plan: In the event emergency medical aid and or treatment is required due to illness, injury or accident during the process of participating in activities at TiAnViCa or at off site activities sponsored by TiAnViCa, I authorize TiAnViCa personnel to secure and retain medical treatment and transportation if needed for myself or for my minor child or ward,  
\_\_\_\_\_ (print legibly).

Authorization includes x-rays, hospitalization, medication and any treatment procedure deemed necessary by the physician or emergency medical personnel. I understand that the Director and Instructor at TiAnViCa is CPR and First Aid Certified, but will defer to emergency medical professionals in any circumstance other than minor illness, injury or accident.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If for minor or ward, that person's name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Home phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Home phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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General Liability Release

*The undersigned is aware that all activities involving horses including but not limited to riding, driving, grooming, leading or events involving horses pose many inherent dangers, risks and hazards including but not limited to bodily injury and physical harm to rider, groomer, leader, handler, side walker, photographer, spectator and/or helper. I (the undersigned) freely and fully assume all such risks, dangers, and hazards and the possibility of injury, death, property damage or loss resulting from such risks, dangers and hazards.*

I hereby agree as follows (initial each number to indicate that you have read, understand and agree):

- \_\_\_\_\_1) To assume and accept all risks, dangers and hazards in connection with my use or my minor child's or ward's use of the facilities at TiAnViCa or any off site activities sponsored by TiAnViCa
- \_\_\_\_\_2) To waive any and all claims that I may have against TiAnViCa and the property owners as a result of my, my minor child or ward's use of the facility or participation in any off site activity sponsored by TiAnViCa
- \_\_\_\_\_3) To release TiAnViCa, it's employees, board of director members, volunteers, spectators, clients, property owners and all people involved with TiAnViCa from any and all liability, rights of action, or causes of action arising out of contract, tort or otherwise for any loss, damage, injury or expense that I, my minor child or ward, next of kin of myself, my minor child or ward, may suffer or incur as a result of use of the facilities or participation in off site activities sponsored by TiAnViCa due to any cause whatsoever
- \_\_\_\_\_4) The undersigned agrees to hold harmless and indemnify TiAnViCa, and any employees, volunteers, board of director members, spectators, clients and or property owners from any and all liability for personal injury, property damage or death suffered by myself, my minor child or ward or by a third party as a result of use of and/or presence at the facility or off site activities sponsored by TiAnViCa
- \_\_\_\_\_5) That, in the event of my, my minor child or ward's injury or death, this release and indemnity agreement shall be effective and binding upon mine and my minor child or ward's heirs, next of kin, executors, administrators and assigns in relation to TiAnViCa, it's property owners and any and all people involved.

**WARNING**

Under Florida law, an equine activity a sponsor or equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risk of equine activities.

Adult:

I acknowledge that I have read and understood this release and indemnity. I am at least 18 years of age and am aware that by signing this document, I am affecting legal rights and liabilities of myself, my heirs, next of kin, executors, administrators, and assigns in relation to TiAnViCa, it's property owners and any and all people involved.

Date: \_\_\_\_\_ Name: \_\_\_\_\_ (print legibly)

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Minor or ward:

I acknowledge that I have read and understood this release and indemnity. I am 18 years of age or older. I have the authority as the parent or legal guardian of \_\_\_\_\_  
(Please print legibly) to sign and release on behalf of the minor/ward so that the minor/ward my participate and use the facilities offered by TiAnViCa. I am aware that by signing this document, I am affecting legal rights and liabilities of the minor/ward, his/her heirs, next of kin, executors, administrators, and assigns in relation to TiAnViCa, it's property owners and any and all people involved.

Date: \_\_\_\_\_ Name: \_\_\_\_\_ (print legibly)

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

Dear Health Care Provider:

Your patient, \_\_\_\_\_

*(participant's name)*

is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

**Orthopedic**

Atlantoaxial Instability - include neurologic symptoms  
Coxa Arthrosis  
Cranial Deficits  
Heterotopic Ossification/Myositis Ossificans  
Joint subluxation/dislocation  
Osteoporosis  
Pathologic Fractures  
Spinal Joint Fusion/Fixation  
Spinal Joint Instability/Abnormalities

**Neurologic**

Hydrocephalus/Shunt  
Seizure  
Spina Bifida/Chiari II malformation/Tethered  
Cord/Hydromyelia

**Other**

Age - under 4 years  
Indwelling Catheters/Medical Equipment  
Medications - i.e. photosensitivity  
Poor Endurance

**Skin Breakdown**

**Medical/Psychological**

Allergies  
Animal Abuse  
Cardiac Condition  
Physical/Sexual/Emotional Abuse  
Blood Pressure Control  
Dangerous to self or others  
Exacerbations of medical conditions (i.e. RA, MS)  
Fire Settings  
Hemophilia  
Medical Instability  
Migraines  
PVD  
Respiratory Compromise  
Recent Surgeries  
Substance Abuse  
Thought Control Disorders  
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,

Roger O. Meadows  
Executive Director  
TiAnViCa Riding Academy, Inc

TiAnViCa Riding Academy, Inc.

PO BOX 7301  
Lakeland, Florida 33811-7301  
863.581.7859 or 863.581.7861

## Participant's Consent for Release of Information

I hereby authorize:

\_\_\_\_\_  
*(person or facility)*

to release information from the records of: \_\_\_\_\_ DOB: \_\_\_\_\_  
*(participant's name)*

The information is to be released to TiAnViCa Riding Academy, Inc  
PO Box 7301  
Lakeland, FL 33807

for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

- Medical History
- Physical Therapy evaluation, assessment and program plan
- Occupational Therapy evaluation, assessment and program plan
- Speech Therapy evaluation, assessment and program plan
- Mental Health diagnosis and treatment plan
- Individual Habilitation Plan (I.H.P.)
- Classroom Individual Education Plan (I.E.P.)
- Psychosocial evaluation, assessment and program plan
- Cognitive-Behavioral Management Plan
- Other:  
\_\_\_\_\_

This release is valid for one year and can be revoked, in writing, at my request.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relation to Participant: \_\_\_\_\_

Please send materials to: TiAnViCa Riding Academy, Inc  
PO Box 7301  
Lakeland, FL 33811

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TiAnViCa Riding Academy, Inc.

PO BOX 7301  
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## Participant's Medical History & Physician's Statement

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Address: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_  
Past/Prospective Surgeries: \_\_\_\_\_  
Medications: \_\_\_\_\_  
Seizure Type: \_\_\_\_\_ Controlled: Y N Date of Last Seizure: \_\_\_\_\_  
Shunt Present: Y N Date of last revision: \_\_\_\_\_  
Special Precautions/Needs: \_\_\_\_\_

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 AtlantoAxial Instability: \_\_\_\_\_

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

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

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

Name/Title: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_

