

Growing to fit the needs  
SINCE 1987



Champlain Adaptive Mounted Program  
*Rider Application*



CHAMP instructors are  
NARHA certified

A member agency of the  
Franklin-Grand Isle United Way.



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**CHAMPLAIN ADAPTIVE MOUNTED PROGRAM**

A volunteer, non-profit tax-exempt corporation

P.O. Box 27

South Hero, VT 05486

802-233-4893

[www.vtchamp.org](http://www.vtchamp.org)

To All CHAMP Riders

The North American Riding for the Handicapped Association (NARHA) sets regulations **for the safety and security of the riders** which all member programs must follow to maintain their accreditation.

**Annually**, before a rider may start the lesson, **NARHA regulations require** completion of each rider's:

- 1. Registration**
- 2. Release forms**
- 3. Medical Treatment form**
- 4. An up-dated Physician's Statement**

The forms follow this message.

Thank you for your cooperation.

*The Board of Directors and Management,*  
CHAMP



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**RIDER'S REGISTRATION AND RELEASE FORM**

**REGISTRATION**

RIDER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/ STATE/ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

SCHOOL OR INSTITUTION PRESENTLY ATTENDING: \_\_\_\_\_

NAME OF PARENT/GUARDIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

**LIABILITY RELEASE**

RIDER'S NAME: \_\_\_\_\_ would like to participate in the Champlain Adaptive Mounted Program. I acknowledge the risks and potential for risks of horseback riding, however I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against the Champlain Adaptive Mounted Program - CHAMP at Good Hope Farm, its board of directors, instructors, therapists, volunteers and/or employees; and the North American Riding for the Handicapped Association; for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in CHAMP's activities. I also understand that under Vermont Law, an equine activity sponsor is not liable for an injury to, or the death of a participant in equine activities resulting from the inherent risks of equine activities that are obvious and necessary, pursuant to 12 V.S.A. 1039

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME BELOW IF SIGNATURE IS BY A PARENT OR GUARDIAN (FOR RIDERS UNDER 18) \_\_\_\_\_

\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_



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**RIDER'S AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

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 of the agency, I authorize Champlain Adaptive Mounted Program - CHAMP at Good Hope Farm 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.

**A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM**

RIDER'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

**IN THE EVENT OF EMERGENCY, CONTACT:**

\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

**SPECIAL MEDICAL INSTRUCTIONS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HEALTH INSURANCE CO.: \_\_\_\_\_ POLICY #: \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME BELOW IF SIGNATURE IS BY A PARENT OR GUARDIAN \_\_\_\_\_

\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_



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**RIDER'S HEALTH CARE UPDATE**

Dear Health Care Provider,

YOUR PATIENT (NAME)

DATE REQUESTED

has been participating in an equine activities program at the **Champlain Adaptive Mounted Program** and is due for a medical status update. Please review his/her previous medical history and provide us with updated information in the space below.

HEIGHT

WEIGHT

DIAGNOSIS:

**UPDATE:** Please include occurrences in the past year of illnesses, hospitalizations, surgeries, changes in medications, treatment, weight or behavior. A list of potential precautions/contraindications are listed on the reverse.

To my knowledge, there is no reason why this person cannot participate in equine activities. However, I understand that the CHAMP, a NARHA premier accredited center will weigh the medical information above against the existing precautions and contraindications. I concur with the review of this persons medical abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implimation of an effective equine activity program.



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NAME

MD DO NP PA OTHER

SIGNATURE

DATE

ADDRESS

AREA CODE/PHONE

LICENSE/UPIN #

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Dear CHAMP Rider,

We may request you to be part of a CHAMP promotional press release. We appreciate your willingness to participate in aiding us to maintain the program through such promotions. For legal reasons we require that you understand and agree to the releases below by filling them out and signing both.

Sincerely,  
Champlain Adaptive Mounted Program

RIDER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/ STATE/ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

**PHOTO RELEASE**

I consent to and authorize the use and reproduction by Champlain Adaptive Mounted Program of any and all photographs and any other audio-visual materials taken of me/my son/my daughter/my ward for promotional use, educational activities, and exhibitions or for any other use for the benefit of the program.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME BELOW IF SIGNATURE IS BY A PARENT OR GUARDIAN \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

**INFORMATION FOR PRINT RELEASE**

I consent to and authorize the use and reproduction of any and all interviews done by members of the press for the purposes of promoting the Champlain Adaptive Mounted Program (CHAMP). I will not hold any CHAMP instructor or volunteer or the authors or publishers of any article liable for statements they may make about me and my participation in this program based on the information provided in interviews. I further understand that I am participating solely for the promotion and fundraising to benefit the CHAMP programs and that there will be no compensation made to me by CHAMP or the publishing organizations.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME BELOW IF SIGNATURE IS BY A PARENT OR GUARDIAN \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_



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## RIDER'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

MUST BE COMPLETED ANNUALLY

RIDER \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/ STATE/ ZIP: \_\_\_\_\_

NAME OF PARENT/GUARDIAN: \_\_\_\_\_

DIAGNOSIS \_\_\_\_\_ DATE OF ONSET: \_\_\_\_\_

**\*\*FOR PERSONS WITH DOWN SYNDROME**

- NEGATIVE CERVICAL X-RAY FOR ATLANTOAXIAL INSTABILITY. X-RAY DATE: \_\_\_\_\_  
 NEGATIVE FOR CLINICAL SYMPTOMS OF ATLANTOAXIAL INSTABILITY.

**SEIZURE TYPE** CONTROLLED?  MILD  MODERATE  SEVERE

RELEVANT NOTES: \_\_\_\_\_ DATE OF LAST SEIZURE \_\_\_\_\_

TETANUS SHOT:  NO  YES DATE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

**MEDICATIONS**

**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.** (See reference list on the next page)

AREAS	YES	NO	COMMENTS
AUDITORY			
VISUAL			
SPEECH			
CARDIAC			
CIRCULATORY			
PULMONARY			
NEUROLOGICAL			
MUSCULAR			
ORTHOPEDIC			
ALLERGIES			
LEARNING DISABILITY			
COGNITIVE IMPAIRMENT			
PSYCHOLOGICAL IMPAIRMENT			
OTHER			

**MOBILITY:** INDEPENDENT AMBULATION  YES  NO CRUTCHES  YES  NO BRACES  YES  NO  
 WHEELCHAIR  YES  NO PLEASE INDICATE ANY SPECIAL PRECAUTIONS: \_\_\_\_\_

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 implementing of an effective equestrian program.

PHYSICIAN NAME (PLEASE PRINT) \_\_\_\_\_

PHYSICIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

PHONE \_\_\_\_\_



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**PHYSICIANS NOTE:** 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. **Circle the relevant conditions for this rider.**

**Orthopedic**

Atlantoaxial Instabilities -  
    includes neurologic symptoms  
Coxas Arthrosis  
Cranial Deficits  
Heterotopic Ossification/  
    Myositis Ossifications  
Osteoporosis  
Pathologic Fractures  
Spinal Joint Fusion/Fixation  
Spinal Joint Instabilities/  
    Abnormalities

**Neurologic**

Hydrocephalus/shunt  
Sensory Deficit  
Seizure  
Spina Bifida/Chiari II Malformation/  
    Tethered Cord/Hydromyelia

**Other**

Age under four 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  
Migrains  
PVD  
Respiratory Compromise  
Recent Surgeries  
Substance Abuse  
Thought Control Disorders  
Weight Control Disorder



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