



# THERAPEUTIC AND RECREATIONAL RIDING CENTER, INC.



## Yearly Update Form

Rider: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
*First Last*

Weight\*: \_\_\_\_\_ Height: \_\_\_\_\_ Gender: M \_\_\_\_\_ F \_\_\_\_\_ **\* For the health and safety of rider, horse and staff, TRRC has a weight restriction of 190 pounds. All riders agree to be weighed prior to riding as a condition precedent to their participation.**

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Alt. Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Parent/Legal Guardian/Caregivers: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

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

### PLEASE complete each row in the following columns!

Please indicate any special needs/concerns:	Yes	No	Comments:
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies (i.e. asthma, bee sting, dust)			
Other			

Please list pertinent information:

MEDICATIONS (include prescription, over-the-counter & herbal; name, dose, and frequency):



\_\_\_\_\_  
Signature of Responsible Party

Date



\_\_\_\_\_  
Required Signature of 2<sup>nd</sup> Person

(Parent/Guardian if under 18)

Date



**TRRC's insurance requires the 2<sup>nd</sup> signature.**

**If there is a special circumstance, please contact Helen Tuel, Director, TRRC, Inc.**



# THERAPEUTIC AND RECREATIONAL RIDING CENTER, INC.



## Authorization for Emergency Medical Treatment

Rider's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Primary Physician Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Co.: \_\_\_\_\_ Policy # \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Current medications: \_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Alt. Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Alt. Phone #: \_\_\_\_\_

### CONSENT PLAN

In the event emergency medical aid or treatment is required due to illness or injury while receiving services or while on the property of TRRC, Inc., I authorize TRRC, Inc. to:

1. Secure and retain medical treatment and transportation as needed.
2. Release client records upon request to authorized individual or agency involved in medical emergency treatment.

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician or emergency personnel. This provision will only be invoked if the person(s) above is unable to be reached:

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

Rider, Parent or Legal Guardian  
**Signed in presence of Center staff**

Printed Name of Above: \_\_\_\_\_ Phone # \_\_\_\_\_

**NON-CONSENT PLAN:** I do not give my consent for emergency medical treatment/aid in the case of illness or injury while receiving services or while on the property of TRRC, Inc.

\_\_\_ Parent, legal guardian or caretaker will remain on site at all times during equine assisted activities

\_\_\_ In the event emergency treatment/aid is required, I wish alternate procedures to take place:

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

Non-Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Rider, Parent or Legal Guardian  
**Signed in presence of Center staff**

Printed Name of Above: \_\_\_\_\_ Phone # \_\_\_\_\_



Since 1983

# THERAPEUTIC AND RECREATIONAL RIDING CENTER, INC.



## Physician's Referral and Medical History

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

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

**Diagnosis Code: ICD-9**

Past/Prospective Surgeries: \_\_\_\_\_

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

Seizure type: \_\_\_\_\_ Controlled: Y\_\_ N\_\_ Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_ Date of last: \_\_\_\_\_

Shunt Present: Y\_\_ N\_\_ Date of last revision: \_\_\_\_\_ Braces/Assistive Devices: \_\_\_\_\_

Mobility: Independent Ambulation Y\_\_ N\_\_ Assisted Ambulation Y\_\_ N\_\_ Wheelchair Y\_\_ N\_\_

Special Precautions/Needs: \_\_\_\_\_

*TRRC, Inc. requires that individuals with Down's syndrome be fully examined for atlantoaxial instability. Once a negative baseline is established, further x-rays are at the discretion of the parents and physician.*

Date of X-rays: \_\_\_\_\_ Radiologist: \_\_\_\_\_ Results: +      -

Neurological symptoms of atlantoaxial instability: \_\_\_\_\_

Please indicate any special needs/concerns:	Yes	No	Comments (if necessary, continue on back)
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies (i.e. asthma, bee sting, dust)			
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 NARHA accredited center, TRRC, Inc., 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_

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

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



**TRRC Fire Evacuation Procedure**

**THE BOTTOM PORTION MUST BE SIGNED and RETURNED TO TRRC!**

**When the FIRE ALARM sounds:**

- All riders and family members must immediately and orderly exit the Rider Support Building, stalls or arena and proceed to the **flag court** at the top of the hill. Delay in exiting the building could interfere with trained staff assisting riders needing support, and the horses.
- Exit the building at the nearest **EXIT** (marked with the red EXIT sign and a spot light).
- All riders on the trails will dismount and remain in radio contact to await further instruction.
- Do NOT return into any building, stall or arena again for ANY REASON.
- A senior staff member has been assigned to sweep the building and assure that every single person is out of the building and all rooms are vacated. Once the building has been checked, the staff will be able to assist with the horses.
- Do NOT go into any of the riding arenas or stalls to help the staff, or to retrieve riders or horses. The staff has been trained on the proper emergency evacuation procedures and will join family members at the flag court. **NO HORSES WILL BE RESCUED UNTIL ALL PEOPLE ARE SECURED SAFELY.**
- Do NOT attempt to assist with the horses. They could become very unpredictable and dangerous with all of the activity, noise and smells. Allow only trained staff members to work with the horses.
- Do NOT drive away from TRRC when the fire alarm sounds even if you have your rider. Moving vehicles will add to the confusion and are too dangerous with all of the movement of people and horses.
- All vehicles and debris must stay clear of the fire lanes and driveway to allow access by Emergency Vehicles.
- Once the "All Clear" is given, staff, riders, and family members can proceed back to the buildings for normal operations.

***Thank you for following these life-saving procedures to assure the safety of our loved ones, both human and animal.***

**By signing below, I agree to follow the Fire Evacuation Procedures**

\_\_\_\_\_

Rider/Guardian Signature Date

**YOUR COPY**

-----  
*Cut Here*

**By signing below, I agree to the Fire Evacuation Procedures**

\_\_\_\_\_

Rider/Guardian Signature Date

\_\_\_\_\_

**Printed Name of Rider**

**TRRC'S COPY**  
**(Fire Evacuation)**



# Therapeutic and Recreational Riding Center, Inc.



## Billing Information Sheet (TH Update)

**PLEASE PRINT ALL INFORMATION**

**Rider Name:**  
*(PRINT)*

\_\_\_\_\_ **Last**

\_\_\_\_\_ **First**

**Address:**  
*(PRINT)*

\_\_\_\_\_ **Street**

\_\_\_\_\_ **City**

\_\_\_\_\_ **State**

\_\_\_\_\_ **Zip**

**Home Phone:**

\_\_\_\_\_ **Work/Alt. Phone:**

**Cell Phone:**

\_\_\_\_\_ **Cell Phone:**

*TRRC utilizes an automated calling and texting service for emergency notifications, including closure due to inclement weather. Indicate preferred contact number(s) with an asterisk (\*) - maximum two please.*

**E-mail address:** *PRINT CLEARLY!*

**Rider DOB:**

\_\_\_\_\_ *mm/dd*

**Health Insurance Provider:**

\_\_\_\_\_ **Diagnosis Code:**

**Preferred method to receive monthly statement:**

**Email**

**Hard mail**

**Printed Names of Parent(s)/Guardian(s):**

*Therapeutic and Recreational Riding Center, Inc. 3750 Shady Lane, Glenwood, MD 21738*

Office: 410-489-5100

Fax: 410-489-3663

trrc01@aol.com

www.trrcmd.org