THERAPEUTIC AND RECREATIONAL RIDING CENTER, INC.

Yearly Update Form (TH)

Rider: _____
Last *First* *M.I.*

DOB: _____ Age: _____ 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/Caregiver: _____

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 2nd Person (Parent/Guardian if under 18) Date

★ ***TRRC's insurance requires the 2nd signature.***
If there is a special circumstance, please contact Helen Tuel, Director, TRRC, Inc.

Therapeutic and Recreational Riding Center, Inc., 3750 Shady Lane, Glenwood, MD 21738
410-489-5100 Fax: 410-489-3663 Trrc01@aol.com www.trrcmd.org

THERAPEUTIC AND RECREATIONAL RIDING CENTER, INC.

Authorization for Emergency Medical Treatment

TRRC
Since 1983

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

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 # _____

THERAPEUTIC AND RECREATIONAL RIDING CENTER, INC.

Medical History and Physician's Statement

TRRC Since 1983

PATH INTERNATIONAL Professional Association of Therapeutic Horsemanship International

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

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: _____

Special Precautions/Needs: _____

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

Braces/Assistive Devices: _____

TRRC, Inc. requires that individuals with Down syndrome be fully examined annually 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 Atlanto-Axial Instability: _____ ☐ Present _____ ☐ Absent

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			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equite-assisted activities and/or therapies. I understand that the PATH Intl. accredited center, TRRC, Inc., will weigh the medical information given against the existing precautions and contraindications. Therefore I refer this person to TRRC, Inc. for ongoing evaluation to determine eligibility for participation. (**PLEASE INCLUDE PRESCRIPTION FORM**)

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____

THERAPEUTIC AND RECREATIONAL RIDING CENTER, INC.

Since 1983

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

YOUR COPY

Rider/Guardian Signature Date

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)

Since 1983

PRINT ALL INFORMATION

DATE: _____

Rider Name: *(PRINT)*

_____ Last

_____ First

Address: *(PRINT)*

_____ Street

_____ City _____ State _____ Zip

Main Phone: _____ **Alt. Phone:** _____

Cell Phone: _____

TRRC utilizes an automated calling service for emergency notifications, including closure due to inclement weather. Indicate preferred contact number with an asterisk (*).

E-mail address: *PRINT CLEARLY!* _____

Rider DOB: _____ *mm/dd/yyyy*

Preferred method to receive monthly statement: **Email** _____ **Hard mail** _____

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

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