



# Reining Warriors

## NEW PARTICIPANT APPLICATION - VETERANS and ACTIVE MILITARY

DATE OF APPLICATION: \_\_\_\_\_

**Circle One**    WTB                    MEDICAL FLIGHT                    VETERAN                    Branch of Service \_\_\_\_\_

WOUNDED WARRIOR PROJECT AFFILIATE    YES    NO

### GENERAL INFORMATION

**Name of Participant** \_\_\_\_\_

Birth date: \_\_\_\_\_ Height \_\_\_\_\_                    Weight \_\_\_\_\_    Gender    M    F

Mailing Address \_\_\_\_\_

Telephone \_\_\_\_\_    **Most used email address** \_\_\_\_\_

Work phone number \_\_\_\_\_    Cell Phone: \_\_\_\_\_

### Emergency Contact:

Name: \_\_\_\_\_    Phone: \_\_\_\_\_

Alternative Phone: \_\_\_\_\_    Relationship: \_\_\_\_\_

**Disability:** Primary Diagnosis: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

How did you hear about Reining Warriors? \_\_\_\_\_

\_\_\_\_\_

Why do you want to participate as a rider with Reining Warriors? \_\_\_\_\_

What are you hoping to achieve as a rider with the program? \_\_\_\_\_

\_\_\_\_\_

Have you ridden a horse before or participated in another therapeutic program? If so, where did you ride?

\_\_\_\_\_

\_\_\_\_\_

Do you have any concerns about riding or being around horses? \_\_\_\_\_

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Do you have any other concerns about participating in the program? \_\_\_\_\_

As a rider with disabilities, side walkers may at times be needed and required to touch you to help with adjusting your position in the saddle, participating in activities and in mounting and dismounting the horse. Will this close contact be a problem for you? If so, how might we accommodate you better?

Is there anything other information you would like to share with us that will help you get the most out of your riding sessions?

Please note that all information disclosed to Hope for Heroes is strictly confidential and rider files are kept secure in our office and are available for review only to the director, riding instructors and specialist staff such as Occupational, Physical or Mental Health Specialists as necessary in providing you with the safest and most beneficial recreational riding experience.

Please return this form to Reining Warriors, 600 Hillsdale Rd, Sinks Grove, WV 24976. Any questions may be directed to Michelle Miller at 304-520-2315. Email: [reiningwarriors@gmail.com](mailto:reiningwarriors@gmail.com)

# Reining Warriors

## Physician's Statement and Medical History / This can be substituted by a WTB Positive Profile (updated annually)

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

Your patient, \_\_\_\_\_ Birthdate: \_\_\_\_\_

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

Wishes to participate in supervised equine activities with our program. In order to safely provide this service, our center requests that you complete the attached Medical History and Physicians Statement Form. Please note that the following conditions may suggest **precautions and contraindications** to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree. Please address occurrences over the past year including surgeries, illnesses, hospitalizations, medications, treatment, weight or behavior.

Diagnosis: primary: \_\_\_\_\_

Onset (please circle one): birth    childhood    adolescence    adulthood

Secondary: \_\_\_\_\_

Please indicate current height \_\_\_\_\_ inches    Weight: \_\_\_\_\_ pounds

Tetanus shot: yes \_\_\_\_\_ no \_\_\_\_\_ date of most recent \_\_\_\_\_

Ambulatory? Yes \_\_\_\_\_ no \_\_\_\_\_ Adaptive equipment used: wheelchair \_\_\_\_\_ Crutches \_\_\_\_\_ braces \_\_\_\_\_ Prosthesis: \_\_\_\_\_

Please describe any special precautions needed: \_\_\_\_\_

### PLEASE LIST ALL CURRENT MEDICATIONS:

1. \_\_\_\_\_ taken for \_\_\_\_\_

2. \_\_\_\_\_ taken for \_\_\_\_\_

3. \_\_\_\_\_ taken for \_\_\_\_\_

Does patient have seizures? If so, what type? \_\_\_\_\_ controlled? \_\_\_\_\_ Date of last seizure \_\_\_\_\_

Signature of rider \_\_\_\_\_ date \_\_\_\_\_

### Physician's Statement (Signature)

To the best of my knowledge, the above information is true and correct. To my knowledge, THERE IS NO REASON WHY THIS PERSON CANNOT CONTINUE TO PARTICIPATE IN SUPERVISED EQUINE ACTIVITIES.

*However, I understand that the therapeutic riding center will weigh the medical information I have provided on the next page against the existing precautions and contraindications.*

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ zip \_\_\_\_\_

Phone: \_\_\_\_\_ Physician's name (please print) \_\_\_\_\_

Medical forms must be dated and signed by a physician. All forms will be updated annually.

**This Information Completed by the Participant**

**Rider's Name:** \_\_\_\_\_

Please 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. **PLEASE BE AS SPECIFIC AS POSSIBLE SO THAT WE MAY BEST SERVE YOUR NEEDS**

**Orthopedic**

- Spinal Fusion
- Spinal Instabilities/Abnormalities
- Atlantoaxial Instabilities
- Scoliosis (more than 30 degrees?)
- Kyphosis
- Lordosis
- Hip Subluxation and Dislocation
- Osteoporosis
- Pathologic Fractures
- Coxas Arthrosis
- Heterotopic Ossification
- Osteogenesis Imperfecta
- Cranial Deficits
- Spinal Orthoses
- Internal Spinal Stabilization Devices

**Issues with or Surgeries in any of the following areas?**

- Auditory
- Visual
  - Vision Without Correction:
  - Vision With Correction:
- Speech
- Cardiac

**Medical/Orthopedic**

- Allergies
- Arthritis
- Cancer
- Poor endurance
- Recent Surgery
- Diabetes
- Fibromyalgia
- Peripheral Vascular Disease
- Varicose Veins
- Hemophilia
- Hypertension
- Serious Heart Condition
- Stroke(CVA)

- Circulatory
- Pulmonary
- Neurological
- Muscular

**Neurologic**

- Hydrocephalus/shunt
- Tethered cord
- Chiari II Malformation
- Hydromyelia
- Paralysis due to spinal cord Injury
- Seizure Disorders
- Multiple Sclerosis

- Orthopedic
- Allergies
- Learning Disabilities

**Secondary Concerns**

- Behavior Problems
- Age two-four years
- Acute exacerbation of chronic Disorder
- Indwelling Catheter

- Mental Impairment
- Psychological Impairment

**SIGNATURE** \_\_\_\_\_ **DATE:** \_\_\_\_\_

## Participant Assessment

(To be completed by participant)

**Please consider each area and circle all words that you feel apply to you and your situation.**

It is okay to skip any question you feel uncomfortable answering.

Committed to the model presented by the Army which is the integration of Body, Mind, Spirit and Family.  
Promoting a sense of becoming, changing, improving and growing.

### **PHYSICAL**

**Mobility:** Ambulation / Independent / Level Surfaces Only / Needs Supervision / Semi-dependent / Dependent / Assistive Devices / Tone / Gross Motor / Fine Motor / Motor Planning / Balance  
**Communication:** Verbal / Words / Phrases / Sentences / Articulation / Signs / gestures / word recall / receptive language / expressive language / difficulty talking to others

**Vision:** Visual Impairment / Assistive Devices / Light sensitivity / Night Vision / Visual Hypersensitivity

**Auditory:** Hearing Impairment / Assistive Devices / Auditory Defensiveness

**Memory:** Long Term / Short Term

**Current Exercise / Therapeutic Regiment:** PT / OT / Weights / Aerobic Exercise / Swimming / Yoga / Walking / Sports

**Activities of Daily Living:** Difficulties bathing / Driving / Shopping / work / recreational  
General Fitness Level? \_\_\_\_\_

### **EMOTIONAL / BEHAVIORAL**

**Emotional:** Depression / Anxiety / PTSD / Trauma / Mood Disorder / Abuse – Physical, emotional, sexual / Fearful / Angry

**Behavioral:** Impulse Control / Hyperactivity / Attention-Focus / Easily Frustrated / Avoidance / Substance Abuse

**Current Therapies / Interventions:** Currently In Therapy? Completed a course of therapy?  
Alcohol Use? Smoker / Non-Smoker? Recreational Drugs?

What do you do to calm down or to motivate yourself to relax, etc.

**HOME & FAMILY**

Married \_\_\_\_\_ Spouse: \_\_\_\_\_ Years married \_\_\_\_\_

Divorced? \_\_\_\_\_

Children \_\_\_\_\_

Names & Ages \_\_\_\_\_

Hometown: \_\_\_\_\_

Current Relationship with Family: Closeness to Family / Maintaining Intimate Relationships / Level of understanding & Sharing thoughts, Feelings / ease of communication

Current Relationships with Friends: How much time to you spend in the company of others?

\_\_\_\_\_

Recreational Interests: What do you do for fun?

\_\_\_\_\_

Clubs / Hobbies / Recreation / Individual vs. group activities

\_\_\_\_\_

**SPIRITUAL**

How connected do you feel to the world around you? Feelings of Isolation / Difficulty staying in the present / Unable to find meaning in life / Unable to see or appreciate beauty / Unable to create positive plans for the future / Unable to feel grounded within myself

Do you have a spiritual community?

\_\_\_\_\_

**Personal Goals**

What would you like to improve in your life in the next few months? \_\_\_\_\_

\_\_\_\_\_

What do you want to do that you can't do now? \_\_\_\_\_

\_\_\_\_\_

What would you like to learn or do around the horses in the next few months? \_\_\_\_\_

\_\_\_\_\_

# Reining Warriors

## PHOTO RELEASE

For valuable consideration and which is hereby acknowledged, the undersigned hereby grant permission to Reining Warriors to take or have taken still and moving photographs and films, including television footage, of the following individual:

Participant's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Please print)

The undersigned hereby consent and authorizes Reining Warriors in its work to use and reproduce the photographs, films, and footage to circulate and publicize the same by all means, including and without limit too, the generality of the newspapers, television, media, brochures, pamphlets, instructional materials, books and clinical materials.

With regard to the foregoing material, no inducement or promises have been made to us/me to secure our/my signature(s) to this release other than the intention of Reining Warriors to use or have used such photographs, films, and footage for the primary purpose of promoting and aiding Reining Warriors and its work.

Consent for Photographs: YES \_\_\_\_\_ NO \_\_\_\_\_ Today's date \_\_\_\_\_

Please print name \_\_\_\_\_ Signature \_\_\_\_\_

# Reining Warriors

## Authorization for Emergency Medical Treatment Form

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_  
( \_\_\_\_\_ (Street/city/zip) \_\_\_\_\_)

Phone \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
home work cell

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Nurse Case Manager's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Health Insurance Company \_\_\_\_\_ Policy# \_\_\_\_\_

Person who is authorized to give temporary assistance or care:

Name \_\_\_\_\_ Phone \_\_\_\_\_ / \_\_\_\_\_  
home work

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

Please describe any medical conditions requiring special precautions or treatment and any medications and

Dosage(s) \_\_\_\_\_

In the event of a medical emergency, I \_\_\_\_\_ (Rider's name) authorize Reining Warriors and/or its designated agent to authorize such medical assistance as it deems necessary. I further authorize any licensed physician and/or medical facility to provide any medical or surgical care and/or hospitalization for the participant deemed necessary or advisable until I am available or able to provide more specific authorization. So authorized:

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

Rider's Signature: \_\_\_\_\_

Medical information is to be updated annually. Rider is responsible for providing Reining Warriors with providing updated information as it becomes available. Reining Warriors will not be responsible for any exclusions. Please return this form to Reining Warriors, Business Address at 600 Hillsdale Rd, Sinks Grove, WV 24976. Any questions may be directed to Michelle Miller at reiningwarriors@gmail.com, phone 304-520-2315.



# Reining Warriors

## RELEASE OF LIABILITY AND ASSUMPTION OF RISK

FOR GOOD AND VALUABLE CONSIDERATION, the receipt of which is hereby acknowledged, the undersigned agrees as follows:

I. ACKNOWLEDGEMENTS

- a. The undersigned acknowledges that all equestrian activities and events are inherently dangerous events and that participation as a competitor, student, and observer, volunteer or paid laborer in any of these events exposes the participant to substantial and serious hazards and risks of property damage, personal injury and/or death.
- b. The undersigned acknowledges that grooming, leading, saddling, mounting, observing, feeding, and any other activity involving horses exposes the actor to substantial and serious hazards and risks of property damage, personal injury, and/or death.
- c. The undersigned further acknowledges that riding horses in the company of other riders and horses, whether for pleasure or in a structured event, exposes such rider to substantial and serious hazards and risks of property damage, personal injury, and/or death.

II. RELEASE OF LIABILITY

- a. The undersigned agrees to release Reining Warriors, its members, agents and employees from any and all claims, demands and liabilities resulting from personal injury, property damage, and/or death arising from the undersigned's participation in any equestrian event, equine activity, or personal equine endeavor on the premises of 600 Hillsdale Rd, Sinks Grove, WV 24976. This release includes claims, demands and liabilities that are known or unknown, foreseen or unforeseen, future or contingent, and includes all claims, demands, and liabilities arising out of negligence by Reining Warriors, its Board of Directors, members, agents, and employees.
- b. The undersigned further agrees to release Reining Warriors from any and all claims, demands, and liabilities by the undersigned for indemnities and contributions arising from property damage, personal injury, and/or death to a third party.

III. ASSUMPTION OF RISK

- a. The undersigned, having acknowledged the inherent danger associated with participation in equestrian riding events and equine activities, whether as a competitor, student, observer, volunteer or paid laborer, hereby voluntarily, knowingly, and expressly assumes the inherent risks and hazards described herein.
- b. The undersigned, having acknowledged the inherent danger associated with riding a horse in the company of other riders and horses, hereby voluntarily, knowingly, and expressly assumes the risks and hazards described herein.
- c. The undersigned, having acknowledged the inherent danger associated with grooming, leading, saddling, mounting, observing, feeding and any other activity involving horses, hereby voluntarily, knowingly, and expressly assumes the risks and hazards described herein.

IV. SEVERABILITY

- a. In the event that any provision of this release and assumption of risk is found to be invalid, unenforceable, or voidable, the remaining provisions shall remain in full force and effect as if this agreement had been executed without the invalid provision.

V. INDEMNIFICATION

- a. The undersigned agrees to indemnify and save and hold Reining Warriors harmless from any and all claims, demands, and liabilities for any and all property damage, personal injury, and/or death asserted by a third party that was occasioned by the undersigned's participation in any equestrian event on the premises of Rainier Acres.

VI. GOVERNING LAW

- a. The undersigned agrees that this agreement shall be subject to the laws of the State of West Virginia and that any dispute regarding this agreement shall be subject to the jurisdiction and venue of the State of West Virginia.

VII. HEIRS, ASSIGNS, SUCCESSORS

- a. The undersigned agrees that this agreement shall be binding upon the heirs, assigns and successors of the undersigned. If the undersigned is a minor child, the parent or guardian of the minor child hereby agrees to the provisions of this agreement in total and is thereby bound by the same, as evidenced by his or her signature below.

DATED THIS \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

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

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

**BARN RULES - initial each and sign at bottom**

- Report ALL accidents or safety incidents to your Instructor immediately.
- Designated smoking area is at the apple tree seating area ONLY.
- Leave all personal firearms in your vehicle.
- No one allowed in hay loft or personal tack room.
- Stay out of horse grazing pastures and unauthorized areas.
- Do not enter where horses are located unless given permission from instructor in charge.
- Visitors, parents, must stay in designated viewing areas only.
- Visitors, parents are not permitted in the arena without instructor permission.
- Working service dogs only at farms. Service dogs only – Dogs must be secured , during lessons and on a leash at all times.
- If you are frustrated, DO NOT take it out on your horse. Rider will respond to instructors with attendance information no later than 24 hours prior to lesson.
  
- It is o.k. to be helpful, but remember the instructors are in charge of teaching the class.
- Treats are o.k., but limit it to one treat after lesson. Be sure to use the Black Treat buckets.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_

## Goals Survey for the Reining Warriors

Please check the following items that you hope to work with while you are here...

Name \_\_\_\_\_

\_\_\_\_\_ improve physical movement

\_\_\_\_\_ improve balance

\_\_\_\_\_ improve motor skills

\_\_\_\_\_ injury recovery

\_\_\_\_\_ develop a new recreation/hobby

\_\_\_\_\_ improve Confidence

\_\_\_\_\_ improve Boundaries

\_\_\_\_\_ increase Sensitivity

\_\_\_\_\_ anxiety reduction

\_\_\_\_\_ improve trust in others

\_\_\_\_\_ improve relationship with others

\_\_\_\_\_ improve understanding and communication skills

\_\_\_\_\_ improve comfort with many people