



## Sarasota-Manatee Association for Riding Therapy, Inc.

4640 CR 675, Bradenton, FL 34211  
941-322-2000

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

[www.facebook.com/smartriders](https://www.facebook.com/smartriders)

Dear Parent, Guardian or Participant,

Thank you for your interest in Sarasota Manatee Association for Riding Therapy, Inc. SMART is dedicated to providing a quality educational and recreational therapeutic horseback riding and carriage driving program for individuals with special needs.

We have established **Participant Eligibility Requirements** to assure that we are providing a safe program for all of our students. Please review these requirements on our website carefully before completing the enclosed application.

Once the entire application package has been completed, please return it to SMART. *The Participant's Medical History & Physician's Statement **MUST** be completed and signed by a Physician before participation can begin.* After we have received and reviewed the application, the participant will be put on the waiting list. We will call you when we are ready to schedule an initial evaluation lesson.

There is a one time evaluation fee of \$35 and an annual membership fee of \$25 per family that is due at your first lesson.

SMART charges a nominal fee of \$25 per group riding lesson which is payable on a weekly or monthly basis. SMART has adopted a policy to never turn away an eligible participant due to financial reasons. Therefore, if you cannot afford to pay the full amount, please request a Tuition Assistance Application. Please be assured that all arrangements and discussions will be kept strictly confidential.

Private lessons are also available at various times throughout the week for \$40 per half hour. Please contact us for more information and availability.

Thank you again for your interest in SMART and we look forward to meeting you soon! Please do not hesitate to call me if you have any questions or concerns at 322-2000.

Sincerely,

*Gail Clifton*

Volunteer Executive Director  
gail@smartriders.org



**Special Olympics**  
Florida



United Way  
of Manatee County, Inc.

Sarasota Manatee Association for Riding Therapy, Inc. is a 501 (c) 3 Organization  
and a Partner Agency United Way of Manatee County. All Contributions are Tax Deductible.  
CH4398 65-0043354

A COPY OF THE OFFICIAL REGISTRATION AND FINANCIAL INFORMATION MAY BE  
OBTAINED FROM THE DIVISION OF CONSUMER SERVICES BY CALLING TOLL-FREE  
(800-435-7352) WITHIN THE STATE. REGISTRATION DOES NOT IMPLY ENDORSEMENT,  
APPROVAL, OR RECOMMENDATION BY THE STA



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*This form **MUST** be signed and dated by a MD, DO, NP, PA or other Medical Professional in the designated area at the bottom of this page!*

## Participant's Medical History and Physician's Statement

Participant: \_\_\_\_\_ DOB: \_\_\_ / \_\_\_ / \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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

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

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

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

Seizure Type: \_\_\_\_\_ Controlled: Yes No Date of Last Seizure: \_\_\_ / \_\_\_ / \_\_\_\_\_

Shunt Present: Yes No Date of last revision: \_\_\_ / \_\_\_ / \_\_\_\_\_

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

Mobility: Independent Ambulation: Yes No Assisted Ambulation: Yes No Wheelchair: Yes No

Braces / Assistive Devices: \_\_\_\_\_

For those with Down syndrome: AtlantoDens Interval X-Rays Date: \_\_\_ / \_\_\_ / \_\_\_\_\_ Result: Positive Negative

Neurologic Symptoms of Atlanto Axial Instability: \_\_\_\_\_

*Please indicate difficulties, medical conditions and/or surgeries in any of the following areas below by checking Yes or No. If yes, please comment.*

| Areas                     | Yes | No | Comments |
|---------------------------|-----|----|----------|
| Auditory                  |     |    |          |
| Visual                    |     |    |          |
| Tactile Sensation         |     |    |          |
| Speech                    |     |    |          |
| Cardiac                   |     |    |          |
| Circulatory               |     |    |          |
| Integumentary / Skin      |     |    |          |
| Immunity                  |     |    |          |
| Pulmonary                 |     |    |          |
| Neurological              |     |    |          |
| Muscular                  |     |    |          |
| Balance                   |     |    |          |
| Orthopedic                |     |    |          |
| 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 and/or therapies including riding and/or carriage driving. I understand that SMART will weigh the medical information given against the existing precautions and contraindications

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_ / \_\_\_ / \_\_\_\_\_

Clearly Print Name & Title: \_\_\_\_\_ License/UPIN Number \_\_\_\_\_

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

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Please Indicate: MD DO NP PA Other \_\_\_\_\_



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## Participant's Application and Health History

Participant's Name: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ Male / Female

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

Phone: \_\_\_\_\_ Alternate Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

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

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

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

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

Care Giver: \_\_\_\_\_ Phone: \_\_\_\_\_

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

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

What medications are you currently taking, including over-the-counter medications? \_\_\_\_\_

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

**Function:** (i.e., mobility skills such as transfers, walking, wheelchair use) \_\_\_\_\_

**Social:** (i.e., work/school included grade completed, leisure interests, relationships, family

Structure, support system, companion animals, fears/concerns, etc.) \_\_\_\_\_

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

### Photo Release

I \_\_\_\_\_ Do I \_\_\_\_\_ Do Not

Consent to and authorize the use and reproduction by SMART (Sarasota Manatee Association for Riding Therapy) of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

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

Parent / Legal Guardian/Participant if over 18



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## RELEASE AND ASSUMPTION OF RISK AGREEMENT

I agree to the following Release and Assumption of Risk Agreement with SARASOTA MANATEE ASSOCIATION FOR RIDING THERAPY, INC., a Florida nonprofit corporation (hereafter referred to as "SMART") as a condition for allowing me or my child /legal ward identified below to enter SMART's premises, surrounding land, and other program locations, be near horses, participate in equine-assisted activities, work near horses, handle horses, use equipment, work with staff and volunteers, and/or receive instruction or guidance while riding, driving, grooming, or handling horses. This is not meant to be a complete list of all activities and will be referred to in this document as "The Activities".

IT IS HEREBY AGREED AS FOLLOWS:

1. I have voluntarily requested, for myself or for my child/legal ward identified below, to engage in any or all of The Activities, now and/or in the future.
2. **Risks.** I understand that anyone engaging in The Activities can suffer bodily injuries, property damage and other injuries including death. Participation in The Activities involves certain inherent risks and, regardless of the care that is taken, it is impossible to ensure the safety of the participant. I understand the risks/dangers inherent in The Activities, and I agree to assume them. I am not relying on SMART to list all possible risks for me or my child/legal ward.
3. **Waiver and Liability Release:** As consideration for SMART allowing me or my child/legal ward to engage in The Activities at any time and at any location, I do hereby voluntarily assume all risks of loss, damage or personal bodily injury including death that may be sustained which may hereinafter occur on account of, or in any way arising from, entry upon the premises or participation in The Activities on or off the premises. I, for my heirs, administrators, personal representatives, or assigns, release and discharge SMART, and all SMART employees, assistants, directors, volunteers, instructors, officers, and owners of horses from any and all claims, demands, damages, actions, omissions, suits, or causes of action (present or future).
3. **Indemnification:** I also understand and agree to indemnify and hold harmless SMART and persons or entities working on behalf of or affiliated with SMART against any and all further claims or damages, cost or expenses incurred by SMART and their employees as a result of an accident, injury or property loss which may occur while I, or my child/legal ward are on or off the premises or engaged in The Activities connected with SMART which may result from negligence of the undersigned or the negligence of SMART, employees, volunteers, instructors, agents, third parties or any combination thereof of SMART. The indemnification shall include reimbursement of SMART'S attorney fees.
4. **ASTM/SEI Headgear:** SMART will provide me or my child/legal ward with an equestrian safety helmet that is ASTM standard and SEI-certified for use when riding or driving horses. I understand that neither SMART nor its assistants or agents can guarantee the suitability of any helmet provided.
5. **Health and Disabilities:** I understand that SMART always recommends that I seek the advice of a physician if I or my child/legal ward is injured, and many of The Activities pose special physical risks to the participant .
6. Should I breach this Release (or any part of it) I agree to pay the attorney's fees and court costs related to such breach incurred by SMART and/or persons directly affiliated with SMART. It is also mutually agreed that any disputes arising under this Release, or any activities that are undertaken pursuant to this document, shall be litigated in a court of proper jurisdiction located in or nearest to Manatee County, Florida.

I understand that when signed, this Agreement is intended to be legal, valid and binding at all times, now and in the future, when SMART permits me or my child/legal ward to engage in any or all of The Activities either on the SMART premises or other designated program locations.

**WARNING: Under Florida Law, an equine activity sponsor or equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.**

NAME OF PARTICIPANT \_\_\_\_\_

SIGNATURE OF PARTICIPANT if 18 or older \_\_\_\_\_ DATE \_\_\_\_\_

Address of Participant: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Cell / other) \_\_\_\_\_ Email: \_\_\_\_\_

I hereby certify that I am authorized to sign this Release and Assumption of Risk Agreement on behalf of the Participant.

SIGNATURE OF PARENT OR LEGAL GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

Print name of Parent or Legal Guardian: \_\_\_\_\_

Address \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Cell / other) \_\_\_\_\_ Email: \_\_\_\_\_



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### Authorization for Emergency Medical Treatment

#### CONSENT PLAN

In the event emergency medical aid/treatment is required due to illness or injury while participating in the Sarasota Manatee Association for Riding Therapy (SMART) program: I authorize SMART to secure and retain medical treatment and transportation if needed. This authorization includes but is not limited to x-ray, surgery, hospitalization, medication and any treatment deemed "life-saving" by the physician. In addition, I authorized SMART to release my records to any individual involved in medical treatment and/or transportation I might need. This provision will be invoked only if the emergency contact person(s) listed below is/are unable to be reached.

Date: \_\_\_\_\_ Participant's Name (print) \_\_\_\_\_ DOB: \_\_\_\_\_

Home Phone Number: (\_\_\_\_) \_\_\_\_\_ Street Address: \_\_\_\_\_

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

#### In case of emergency, contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number(s): (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number(s): (\_\_\_\_) \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

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

Allergies to Medications: \_\_\_\_\_

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

Health Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**Consent Authorized Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Parent / Legal Guardian/Participant if over 18)

#### NON-CONSENT PLAN

I do not give my consent for emergency medical treatment in the case of illness or injury while participating in the SMART program. In the event of emergency treatment aid is required, I wish the following procedures to take place: (list procedures) \_\_\_\_\_

Date: \_\_\_\_\_ Participant's Name (print): \_\_\_\_\_

***Parent or Legal Guardian will remain on site at all times during equine assisted activities.***

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

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### Participant Information

Participant's Name: \_\_\_\_\_

Describe briefly what you think this participant's strengths and talents are:

Describe briefly what you think this participant's weaknesses are:

Check those that accurately describe the participant:

#### Best Teaching Strategy

- Auditory
- Visual
- Kinesthetic
- Visual-Kinesthetic
- Auditory-Visual
- Auditory-Visual-Kinesthetic

#### Laterality

- Is able to differentiate between his/her left hand
- Is able to differentiate between his/her right hand
- Appears to use both right and left sides equally

### Motor Coordination and Body Image

- Has tightly muscled body
- Has low muscle tone
- Has average muscle tone
- Is coordinated and plays in many sports well
- Has difficulty playing some sports
- Does not like to be touched
- Does not seem to be aware of his body in space
- Pays attention to body cues, knows when hungry, tired and takes care of bodily needs
- Is skin sensitive and complains at times that clothing is too rough or hurts
- Compulsively overeats
- Stumbles and trips, runs into things or knocks things over often

### Social and Emotional Adjustment

- Appears to be appropriately independent, self-reliant, and mature for age
- Appears to have a positive self-image
- Can be very hard on him or herself
- Whines, complains and generally manipulates
- Is able to get along with others
- Is direct and can ask for what he/she needs and wants
- Performance is uneven and marked good and bad days
- Tires easily
- Is argumentative and oppositional at times
- Wants to please
- Has anxiety exhibited by stomach aches, headaches or other physical symptoms
- Shows anxiety by chewing on clothing, toys or own body

### Observed Behaviors

- Distracted by internal stimuli
- Distracted by external stimuli
- Needs constant reminders to stay on task
- Needs occasional reminders to stay on task
- Is easily bored
- Needs several minutes to process information before acting
- Needs repetition in order to internalize feedback or instruction
- Once something is learned can remember to correct his/herself
- Gives up when frustrated
- Is determined and keeps trying

Do you have any other comments that would help us better understand the participant?

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

Relationship to participant: \_\_\_\_\_

**Acknowledgement and Consent to Release Records to  
Manatee County Government**

***This form should be completed only for Participants residing in  
Manatee County  
under the age of 18 years old.***

Name of Participant: \_\_\_\_\_

I hereby acknowledge and consent to release to Manatee County Government's Representative the Agency records of my child or legal ward from Sarasota-Manatee Association for Riding Therapy, Inc. (SMART). These records relating to the program or delivery of services may be required by the County for purposes of monitoring and evaluating services.

I also understand that to the extent records are provided to the County, same shall become public records under Chapter 119, Florida Statutes and may be subject to any applicable state or federal exemptions and be inspected or copied by third persons.

\_\_\_\_\_  
**Signature of Parent or Legal Guardian**

\_\_\_\_\_  
**Date**