



Sarasota Manatee Association for Riding Therapy, Inc.

4800 CR 675, Bradenton, FL 34211

941-746-1493

www.smartriders.org

CH4398

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.

SMART charges a nominal fee of \$20 per lesson which is payable on a weekly or monthly basis. SMART has adopted a policy to never turn away an eligible rider due to financial reasons. Therefore, if you cannot afford to pay the full amount, please return the enclosed Tuition Assistance Application. Please be assured that all arrangements and discussions will be kept strictly confidential.

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 746-1493.



Sincerely,

Bridget Brunson

Program Director

bridget@smartriders.org



Special Olympics
Florida

Enc: Participants Medical History & Physician's Statement
Participants Application and Health History
Release and Assumption of Risk Agreement
Authorization for Emergency Medical Treatment
Participant Information
Tuition Assistance Application
Release to MC



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

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 STATE



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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: Y N Date of Last Seizure: ___ / ___ / _____
 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: _____

For those with Down Syndrome: AtlantoDens Interval X-Rays Date: ___ / ___ / _____ Result: + -

Neurologic Symptoms of AflantoAxial Instability: _____

	Y	N	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 the NARHA center 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, Bridge Creek Inc., and all SMART employees, assistants, directors, volunteers, instructors, officers, land owners, 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, Bridge Creek, Inc., 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, Bridge Creek, Inc., 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, Bridge Creek Inc., 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: _____
(Parent / Legal Guardian / Participant if over 18)



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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: _____



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Tuition Assistance Application

1. Please complete the application below if requesting financial assistance for therapeutic riding / driving lessons.
Note: A separate form is required for each child
2. Attach a copy of the first page ONLY of your most recently filed IRS Tax Return

Upon receipt and after review of all the required documentation, your suggested lesson fee will be determined. A sliding scale fee schedule is used to determine appropriate fees. All information is kept confidential.

Please note; if your child is receiving tuition assistance, he/she must attend a minimum of at least three (3) classes per month.

A new application and supporting documentation are required each year.

Participant's Name: _____ Age: _____

Address: _____ City/State: _____ Zip: _____

Marital Status of Parent/Guardian/Participant: Single Married

Participant Lives With (check one) Mother Father Both Other: _____

Household Total: _____ Number of Adults: _____ Number of Children: _____

Parent/Guardian/Participant Social Security No.: Relationship:

Total Family Income (including Child Support, AFDC, and all other sources of income):

- Less than \$15,000
 \$15,001 - \$20,000
 \$20,001 - \$30,000
 \$30,001 - \$45,000
 \$45,001 - \$55,000
 \$55,001 - \$70,000
 over \$70,000

Are you currently receiving any Government support? Yes No

If so, explain: _____

Is the participant receiving free or reduced lunch? Yes No

Grade: _____ School Name: _____

Signature (Parent/Guardian/Participant if over 18 and requesting aid)

Date

Applications must be accompanied by the first page ONLY of your most recently filed IRS Tax Return!

Acknowledge and Release to Manatee County Government

(Only for Participants residing in Manatee County under the age of 18 years old.)

Name of Participant: _____

I hereby acknowledge and release to Manatee County Government the Agency records of my child or legal ward from Sarasota Manatee Association for Riding Therapy (SMART). These records may be required by the County for purposes of monitoring and evaluating services.

I understand that SMART's records relating to this program may be public record under Chapter 119, Florida Statutes.

Signature of Parent or Legal Guardian

Date