NORTH COUNTRY RIDE

PO Box 312, Esko MN 55733
Ph: (218) 879-7608
Fax: (218) 879-7609
ncride@gmail.com

Please complete all forms and return to North Country RIDE

Participant's name: _____

Circle the session(s) you want to attend: **SPRING** **SUMMER** **SUMMER-2** **FALL** **WINTER**

Circle your preferred day: **MONDAY** **TUESDAY** **WEDNESDAY** **THURSDAY**

What time of day works best?
Morning 9:00 - 12:00 ___ Afternoon 1:00 - 4:00 ___ Evening 5:00 - 7:00 ___

Comments: _____

Will person attending with participant be available to volunteer during class? Yes ___ No ___

Participant Date of Birth: _____ Age: _____ Height: _____ Weight: _____ (**200 lb. limit**)

Address: _____ City: _____ Zip: _____

Preferred Phone: _____ Email: _____

Parent/Legal Guardian: _____

Parent/Guardian phone: _____

Address (if different):_____

Are you a returning participant? Yes___ No___

Person responsible for scheduling:
Name: _____ Relationship: _____
Phone: _____
Email: _____

Person/County responsible for billing: _____
Phone: _____ Email: _____

Where did you hear about North Country RIDE? _____

"A community where all people can find growth and healing through a connection with horses"

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HEALTH HISTORY

Diagnoses: _____ Date of Onset: _____

Areas of Special Need	Yes	No	Comment if Yes.
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Arm or Leg Braces			
Bone/Joint			
Muscular			
Cognitive			
Allergies			Epi-pen? Yes___ No___

Describe participant's abilities or difficulties, and assistance or equipment needed.

PHYSICAL FUNCTION (Mobility such as transfers, walking, wheelchair use)

_____

_____

SOCIAL FUNCTION (Work/school, leisure interests, relationships, family/support systems, pets)

_____

_____

MENTAL FUNCTION (What area in your mental wellness are you looking to better being with horses?)

_____

_____

GOALS (What would you like to accomplish?)

_____

_____

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PHOTO RELEASE

I DO____ I DO NOT ____ consent to and authorize the use and reproduction by North Country RIDE 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 (this includes the website, North Country RIDE Facebook & newspapers).

PHOTO POLICY: Photos taken of riders or volunteers other than your child/family member at North Country RIDE may not be posted on social media. Please respect the privacy of all participants and volunteers.

It is our duty to advise you that equine assisted activities and horseback riding could lead to accidents that could cause injury or death.

LIABILITY RELEASE

_____ (participant's name) would like to participate in the North Country RIDE program activities. I acknowledge the risks and potential risks of equine assisted activities. I hereby, for myself, my heirs and assigns, executors, or administrators, waive and release forever all claims for damages or other compensation against North Country RIDE, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my daughter/son, my ward may sustain while participating in program activities at North Country RIDE, sponsored by North Country RIDE or any activity related thereto.

*North Country RIDE reserves the right to remove a rider from the horse for reasons of safety of all participants, or as a disciplinary measure.

_____ _____
Consent Signature, legally competent participant, parent, or legal guardian Date

_____ _____ _____
Print Consenter's Name Relationship Phone

_____ _____ _____ _____
Consenter's Address City State Zip

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of North Country RIDE, this form is needed for quick response and is kept readily available to staff.

I authorize North Country RIDE to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to authorized individual/agency involved in the treatment of the medical emergency.

Name of Participant: _____ DOB: _____

Signature of participant/parent/guardian: _____

Person to be contacted in event of emergency: *Please print clearly:*

Contact: _____ Phone: _____
Name Relationship

Contact: _____ Phone: _____
Name Relationship

Physician's Name: _____ Phone: _____

Preferred Hospital: _____

Any medical condition requiring special precautions or treatment: _____

List any allergies: _____

I give my consent for emergency medical treatment/aid for _____ (Rider's name) in the case of illness or injury during the process of participating in program activities or while being on the property of North Country RIDE. I agree to be personally responsible for payment of any hospital, clinic, laboratory, emergency room, transportation charges which are not covered by insurance.

_____ _____ _____
Consent Signature of participant, parent or legal guardian Relationship Date

_____ _____
Print Name Phone

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PARTICIPANT DATA 2025

DO NOT WRITE NAME ON THIS FORM. This information is **CONFIDENTIAL** and used for statistical purposes only.

Years attending NCR: _____

Gender: ___Female ___ Male

Age group:

___Preschool (under 5)
___Child (6-11)
___Youth (12-14)
___Adolescent (14-18)
___Adult (19-65)
___Senior (over 65)

Racial/Ethnic Background:
___African American /Black
___Asian
___Caucasian /White
___Hispanic /Latino
___Native American
___Other

Zip Code: _____

Annual Income Level:

___under $20,000

___$20,001-30,000

___$30,001-$40,000

___$40,001-$60,000

___> $60,000

Thank you for including the demographic data that North Country RIDE uses when applying for funding.

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PHYSICIAN STATEMENT

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

Address: _____City: _____State: _____ Zip: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Seizures: Yes ___ No___ Type: _____ Controlled: Yes ___ No___ Date of Last Seizure: _____

Special Precautions/Needs: _____

Mobility: Independent____ Cane____ Crutches____ Braces____ Walker____ Wheelchair____

For those with **Down Syndrome**: Neurologic Symptoms of Atlantoaxial Instability: Present ____ Absent___

Please indicate current or past special needs in the following areas, including surgeries. These conditions may suggest precautions and/or contraindications to equine activities.

Systems/Areas:	Yes	No	Comment, if Yes
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Medications			
Other			

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INFORMATION FOR PHYSICIAN

The following conditions may suggest precautions and contraindications to equine-assisted activities. Therefore, when completing this form, please circle conditions are present and notate to what degree.

Orthopedic
Atlantoaxial Instability
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification
Joint subluxation/dislocation
Kyphosis
Lordosis
Myositis Ossificans
Osteoporosis
Pathologic Fractures
Scoliosis
Spinal Fusion/Fixation
Spinal Instability/Abnormalities
Spinal Orthoses
Spinal Stabilization Devices (Internal)

Neurologic
Chiari II malformation
Hydrocephalus/Shunt
Hydromyelia
Seizure Disorders
Spina Bifida /Tethered Cord

Medical
Allergies
Blood Pressure Control
Heart Conditions
Hemophilia
Hypertension
Medical Instability
Migraines
PVD
Recent Surgeries
Respiratory Compromise
Stroke
Varicose Veins

Other
Acute exacerbation of chronic disorder
Age - less than 4 years
Behavior Problems
Indwelling Catheters
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

Thank you very much for your assistance. For more information on equine-assisted activities, feel free to contact: North Country RIDE, PO Box 312, Esko MN 55733 (218)879-7608

Given the preceding diagnosis and medical information, this person is not medically precluded from participation in supervised equestrian activities. However, I understand that North Country RIDE will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to North Country RIDE for ongoing evaluation to determine eligibility for participation.

Physician Name (Please Print): _____

Signature: _____ Date: _____

Office Address: _____

City, State, Zip: _____ Phone: _____