Briggs Stable

Therapeutic Riding Division
623 Hanover Street, Rte. 139
Tel: 781-826-3191
Fax: 781-829-0091

Statement of Participant Eligibility

Briggs Stable Therapeutic Riding Division offers Therapeutic Riding Services to individuals with special needs. Eligibility for participation in the Therapeutic Riding Section of Briggs Stable's lesson program is based on the individual's ability to participate meaningfully and SAFELY, provided there is a NARHA (North American Riding for the Handicapped) Certified Instructor and an appropriately sized horse to accommodate the individual needs of the rider.

Briggs Stable has on staff NARHA Certified Instructors and NARHA members, therefore, Briggs Stable adheres to the precautions and contraindications as recommended by the Medical Committee of NARHA. Briggs Stable's therapeutic riding instructors also adhere to the code of Ethics set by NARHA. For that reason, all prospective riders are evaluated by our professional staff before they are accepted into therapeutic riding lessons.

There are individuals whom the Briggs Stable Therapeutic Riding programs are deemed inappropriate due to the nature of therapeutic riding. This determination is made on the basis of physical/behavioral limitations, recommendations from their professional medical advisors or the inability for Briggs Stable to presently provide the steed or equipment necessary to complete safe/effective lessons. Determinations of this kind will be made during the initial orientation/ assessment.

In accordance to NARHA standards, riders accepted into the program are required to take part in periodic progress reviews. During these reviews, or following any unusual incidences during a lesson, Briggs professional staff may find that continuance in the program is inappropriate. Therefore, Briggs Stable reserves the right to discontinue the participation of a given individual in its programs when it is deemed that discontinuance is in the best interest of Briggs Stable or the rider concerned.

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Participation Application

Warning: Under Massachusetts Law, an 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, pursuant to Chapter 128, Section 2D of the General Laws.

Please Print

Date:______________________ DOB: _____/______/_____

Name:__________________________ Home Phone:_______________________

Address:________________________ Day Phone:________________________

________________________________ Cell Phone:_________________________

Height:_________ Weight:__________ Email:_____________________________

Diagnosis:____

Parent's/ Guardian's Name:____

****Riders that have allergies to bee stings must bring an epi-pen with them. Please inform the staff about the allergy when you arrive.**

Additional Information

What are the greatest needs of the participant?_______________________________
____

Does she read/print name?____
Is she mentally impaired?____
Is she physically disabled?____
Is the rider incontinent?_______ Bowel? Bladder? Can the rider toilet alone?_______
Describe any special procedures or equipment needed:__________________________
Does the rider have a stoma (ostomy)?_________ Procedures needed?_____________
Does the rider use any form of supportive/assistance equipment?_________________

Signature of Rider/ Guardian:__________________________ Date:_______________

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Authorization for Emergency Medical Treatment

In an emergency or medical/aid/ treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Briggs Stable to secure and retain medical treatment and transportation if needed and/or release client records upon request of the authorized individual or agency involved in the medical emergency.

Name:____________________________ Parent/Guardian's Name:__________________
Address:__________________________ Day Phone:_____________________________
__________________________________ Cell Phone:_____________________________
Home Phone:_______________________

In the event of an emergency where the parent or guardian cannot be reached, contact:
1. Name:______________________________ Phone:_________________________________
Relation:_______________________ Cell Phone:______________________________
2. Name:_____________________________ Phone:_________________________________
Relation:______________________ Cell phone:______________________________

Physician's Name:_________________________ Phone:___________________________
Preferred Medical Facility:____
Health Insurance Co:___________________________ Policy #:_________________________

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment deemed "life saving" by the physician. This provision will only be invoked if the person listed below is unable to be reached.

Signature:__________________________________ Date:___________________________

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:________
____
____
____

PLEASE INFORM YOUR EMERGENCY CONTACTS OF YOUR NON-CONSENT CHOICE!!!!!!

Non-Consent Signature:________________________________ Date:_____________________

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Information for Physician

Below is a list of conditions that need to be taken into consideration before allowing therapeutic horseback riding. These conditions, if present, may bring precautions and/or contraindications to therapeutic horseback riding. Please note on the following form whether or not these conditions are present and to what degree.

Orthopedic

Coxas Arthrosis
Cranial Deficits
Hetereotopic Ossification
Hip Subluxation and Dislocation
Internal Spinal Stabilization Devices
Kyphosis
Lordosis
Osteogenesis Imperfecta
Osteoporosis
Pathological Fractures
Scoliosis
Spinal Abnormalities
Spinal Fusion
Spinal Instabilities
Spinal Orthoses

Medical / Surgical

Allergies
Cancer
Diabetes
Hemophilia
Hypertension
Peripheral Vascular Disease
Poor Endurance
Recent Surgery
Serious Heart Condition
Stroke (Cerebrovascular Accident/ Injury)
Varicose Veins

Neurologic

Chiari ll Malformation
Hydrocephalus/ Shunt
Hydromyelia
Microcephalus
Paralysis due to Spinal Cord Injury
Seizure Disorder
Spina Bifida
Tethered Cord

Secondary Concerns

Acute Exacerbation of chronic disorder
Age: under two years
Age: two – four years
Behavioral Problems
Indwelling catheter
Severe Psychological Condition

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Riding Authorization

Riders' Medical History and Physician Statement

This form must be completed by a licensed physician in order for a rider to participate in therapeutic riding lessons at Briggs Stable. Forms need to be updated annually.

Date:________________ DOB_____/_____/_____

Rider's Name:_________________________ Day Phone:_____________________________

Address:_____________________________ Cell Phone:_____________________________

_____________________________________ Parent's Name:_________________________

Diagnosis:____

____

Date of Onset:_________________ Height:________________

Weight:_______________

Tetanus Shot: Yes _____ No ______ Date _____________

Medications:____

Side effects:____

FOR RIDERS WITH DOWN SYNDROME ONLY:

Negative Cervical X-Ray for Atlantoaxial Instability Yes_______No______

Negative for Clinical Symptoms of Atlantoaxial Instability Yes_______No______

X-Ray Date:________________________

Riders and Caregivers are urged to voluntarily enclose an up to date copy of the vaccination records along with this form.

Please indicate if the rider has/had a problem and or surgeries in any of the following areas. If yes, then please provide a comment.

Areas	Yes	No	Comments
Allergies			
Auditory			
Cardiac			
Circulatory - PVD - Postural Hypotension			
Hemophilia			
Hydrocephalus - Shunt			# of revisions: Date of last revision:
Learning Disability			
Mental Impairment			
Muscular - Contractures			Botox Injections?
Neurological - Seizures - Controlled ?			Last Seizure:
Orthopedic			
Pain - Where - What degree			
Psychological Impairment - Severity - Therapy			Are there any triggers or things to avoid?
Pulmonary - Asthma/ COPD			
Sensory Loss			
Speech			
Visual			Glasses Y____ No_____
Other			

PLEASE CONTINUE ON TO THE NEXT PAGE

Skeletal Information	Yes	No	Explain Degree and Comment
Down Syndrome only Evidence of Spinal Cord Compression			
Braces			Last X-Ray:
Cranial Defects			
Dislocating Joints			
Fractures - Location - Healed (date)			
Heterothrophis/Ossification			
Joint Disease			
Kyphosis/ Lordosis Type			Degree:
Laminecotomy/Fusion			
Medications			
Osteoporosis			
Subluxing Joints			
Scoliosis/ Degree/ Type			
Spinal Abnormality			
Spinal Column Injury			
Spondylolistheses			
Other			

Mobility:

Ambulatory: Yes_________ No__________
Independently: Yes_________ No__________
Crutches: Yes_________ No__________
Braces: Yes_________ No__________
Wheelchair: Yes_________ No__________
Prosthetics: Yes_________ No__________
Purpose:____
Special Precautions:____

Please include any additional information that may help us with our success with your client. Thank you.____
____
____
____

Riding Authorization

To be signed by the physician. Stamps are not accepted.

To my knowledge there is no reason why ______________________________ cannot participate in supervised equestrian activities and events. However, I understand that the Therapeutic Riding Instructor at Briggs Stable will review and weigh the medical information above against the existing precautions and contradictions set by NARHA. I concur with a review of this person's abilities/limitations by a licensed/ credentialed health professional (PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Please initial one of the following options

I do recommend horseback riding for the above patient__________________

I do NOT recommend horseback riding for the above patient__________________

Recommended Frequency:____

Precautions:____

____

Physician's Signature:___________________________ Date:_________________

Physician's Name:______________________________ Phone:___________________

Address of Practice:____

____

____

BRIGGS STABLE, LLP
GENERAL RELEASE OF LIABILITY AND INDEMNIFICATION AGREEMENT

I CLASSIFY MYSELF AS A
BEGINNER [ ] INTERMEDIATE [ ] ADVANCED [ ] RIDER.

RIDER

NAME______________________________________ EMERGENCY #____________________________________

ADDRESS__________________________________ PERSON TO CONTACT_____________________________

CITY/STATE_______________________________ NAME OF INSURANCE CO.___________________________

TELEPHONE #______________________________ POLICY #____

PARENT/LEGAL GUARDIAN

NAME_____________________________________ ADDRESS____

TELEPHONE #_____________________________ CITY/STATE_______________________________________

This Release and Indemnity Agreement is made and entered into by and between Briggs Stable LLP, a Massachusetts corporation ("Owner"), the undersigned person who wishes to use the property, facilities and services of Owner and, if such person is a minor, his parent or guardian (the undersigned and his parent or guardian are referred to collectively as "Rider"). In consideration of the use, today and on all future dates, of the property facilities and services of Owner, Rider hereby expressly agrees to the following:

1. It is the sole responsibility of Rider to carry full and complete healthcare insurance coverage and loss insurance coverage for his personal property and himself.

2. Rider understands that horseback riding is an inherently dangerous activity. Rider voluntarily assumes **ANY AND ALL RISKS INVOLVED IN OR ARISING FROM RIDERS USE OR PRESENCE UPON OWNER'S PROPERTY AND FACILITIES** including, but not limited to, the risks of death, bodily injury, property damage, falls, kicks, bites, collisions with vehicles, horses or stationary objects, fire or explosion, the unavailability of emergency medical care, or the negligence or deliberate act of Owner or its affiliates or their officers, directors, shareholders, partners, agents, employees and representatives.

WARNING

UNDER MASSACHUSETTS LAW AN 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, PURSUANT TO CHAPTER 128, SECTION 2D OF THE GENERAL LAWS.

3. Rider releases, discharges and agrees to indemnify and hold harmless and hold harmless Owner and its affiliates and their officers, directors shareholders, partners, employees, agents and representatives and their respective successors and assigns (collectively, Releases"), from all actions, causes of action, claims, liabilities, judgments, costs expenses and other obligations, whether or not occasioned by any Releasee's negligence, arising out of Rider's use or presence upon Owner's property or facilities, including without limitation, those based on death, bodily injury or property damage. Rider **AGREES NOT TO SUE** any of the Releasees in connection with any claim arising out of Rider's use of or presence upon Owner's property or facilities. The indemnification called for hereunder shall include Rider being responsible for the payment of Owner's attorneys fees and costs.

4. Rider agrees to abide by all of Owners rules and regulations.

5. This Agreement shall be construed so as to permit its enforcement to the fullest extent permissible under the laws of the Commonwealth of Massachusetts. If any provision hereof is held invalid or unenforceable, the remaining provisions shall be given effect without regard to the invalid or unenforceable provision. This Agreement shall be governed by the laws of the Commonwealth of Massachusetts without regard to its conflict of laws rules. Rider hereby consents and submits to the exclusive jurisdiction and venue of the courts located in the County of Plymouth, Commonwealth of Massachusetts in connection with any action or proceeding arising out of or relation to this agreement. This Agreement may not be changed other than by writing specifically referring to this document and signed by a duly authorized officer of Owner. This Agreement shall be binding upon rider's spouse heirs, successors, executors, administrators and legal representatives.

THIS DOCUMENT IS THE PROPERTY OF BRIGGS STABLE, LLP AND WILL REMAIN IN FORCE UNTIL SPECIFICALLY WITHDRAWN BY ALL PARTIES HERETO.

By Signing the line below you are acknowledging that you have read and understood the above release and indemnity agreement.

Date_______________ X____

I hereby consent to any medical, dental or surgical treatment or procedure of an emergency nature that is reasonably necessary to save the life of the rider named above or to restore the Rider to health.

Date_______________ Riders Signature X____

Date_______________ Parent/Legal Guardian Signature____