



Dear Future REINS Family,

We look forward to meeting you and your future participant. Please fill out the Participant Enrollment Packet and return to us via email or mail at your earliest convenience.

Although there is a current waiting list, we will attempt to fit you in as soon as possible. Once all paperwork is completed, and submitted, you will be contacted for further scheduling information.

We are very excited to meet you and get to know your family, as you are now part of ours!

Feel free to call and schedule an in-person tour at our facility if you have not already done so. Our facility is our happy place, and we cannot wait to share it with you!

Please submit paperwork to:

Maggie Kibler, Program Director
maggie@reinsprogram.org

Sincerely,
The REINS Team





PARTICIPANT ENROLLMENT PACKET

ENROLLMENT:

- Fill out and sign the enclosed forms completely and return them to REINS.
- We do have an extensive waitlist. You will be placed on the waitlist as soon as all forms are completed, and notified when an appropriate time slot is available.

CANCELLATION/MAKE UP POLICY:

- Please notify us at least 24 hours prior if you need to cancel your regularly scheduled lesson. We understand things come up and life is busy! However, if there are more than 3 no shows/ no calls in one trimester, your spot may be forfeited.
- If notified in advance, we may be able to reschedule your lesson for a different day/time that week. However, makeup lessons are not guaranteed
- No refunds are given for lessons missed.

PROGRAM FEE POLICY:

****Invoices will be sent at the beginning of each trimester and fees are due by the end of the Trimester****

REINS Schedule is based on Trimesters. The current fee per Trimester (13-15 weeks):

- \$400.00-Therapeutic Riding
- \$400.00-Unmounted Equine Assisted Learning Services
- Payment plans and partial scholarships are available, inquire with Program Director

To make payments:

- Cash/Check/Credit Card in the program office.
- Auto-pay with Credit card on file (forms are available in the office)
- Online: <https://reinsprogram.org/about-us/rider-information/lesson-payment/>

Program Fees cover about 25% of actual cost. REINS appreciates any help during fundraisers.

CALENDAR:

- REINS holds classes Monday – Saturday, Closed Sunday
- Closed for all major holidays, Spring Break, Thanksgiving, Winter Break, and Summer Break (dates fluctuate each year)
- Closure reminders will be posted via social media, web site, newsletter, emails, and our yearly calendar.
- Extreme Weather Closures: At staff discretion, based on safety for participants, volunteers, and staff.
- Rainy weather, extreme heat, and high winds classes will be canceled for your safety. Please call with any questions.

Please note: Makeup lessons for weather related closures are not typically available.

APPAREL:

- Horseback Riding helmets are required (SEI Equine approved only)
- Appropriate clothing for weather conditions. Boots or sneakers (no sandals/crocs)



PARTICIPANT/CONTACT INFORMATION SHEET

Participant's Information

Student's Name: _____

Date of Birth: _____ Gender: M F Weight: _____

Current Diagnosis: _____

Current Treatment/Services: _____

Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____

Participant is a (circle one): Minor Adult w/a legal guardian Independent adult

Participant/Parent/Guardian Name _____

Cell Number: _____ Occupation: _____

Other Parent/Guardian Name: _____

Cell Number: _____ Occupation _____

Is either parent or guardian an active member of the military? Yes No

Is the participant a client of San Diego Regional Center? Yes No

Contact Information

Person in charge of participant's schedule: _____

Relationship to participant: _____ Preferred phone number: _____

Contact Information in charge of billing: _____

Address (if different from above): _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Primary email: _____

Would you be willing to help REINS with collecting donations or volunteer hours? Yes No



QUESTIONNAIRE & HEALTH HISTORY

Has the participant had previous experience with therapeutic riding? YES NO

If yes, please explain:

Goals: What are you hoping to accomplish by participating at REINS?

Comments: please give any info that you feel will be helpful in lesson planning

Please answer the following to help us best prepare for your arrival and evaluation:

Does the participant...	<u>YES</u>	<u>NO</u>	<u>Comments</u>
Walk independently?			
Have poor balance sitting/standing balance?			
Have speech/language difficulties?			
Have problems with fine motor skills?			
Have problems with gross motor skills?			
Have allergies or breathing problems?			
Have pain?			
Have emotional/behavioral problems?			
Have heart/circulation problems?			
Have short term/long term memory loss?			
Have a fear of heights?			
Have a fear of horses or animals?			

Participant/Guardian Signature: _____ Date: _____



SEIZURE INFORMATION FORM

Participant Name: _____ **Date:** _____

Does the participant have seizures? **Y** **N** If yes, please fill out the following form.

What may cause the seizures?

On average, how often do they occur?

Are there any warning signs before a seizure starts?

What is the average duration of a seizure?

How does the participant feel and behave after a seizure? How long does this last?

How would you like us to handle the situation, should a seizure occur while riding?

Is there anything else that we need to know about the seizures?

Participant/Guardian Signature: _____ **Date:** _____



PHYSICIAN'S APPROVAL FORM
To be Signed and Dated by Current Doctor

Patient's Name: _____

Parent Name and Contact # _____

Patient's date of birth: _____ Height: _____ Weight: _____

Medical History

Diagnosis: _____

Date of onset: _____

Primary Disability: _____

Other Concerns: _____

Hospitalizations: _____

Shunts/Assistive Devices: _____

Seizures/Allergies: _____

Present Medications: _____

Physical Evaluation

Skin/Circulation: _____ Neuro/Sensation: Heart/Lungs: _____

Balance/Coordination: _____ Bowel: _____

Bladder: _____ Vision: _____

Hearing: _____ Speech: _____

Spasticity/Rigidity: _____

FOR PARTICIPANTS WITH DOWN SYNDROME:

Neurological exam for Atlantoaxial Instability: _____ Present _____ Not present

Other Precautions/Contraindications to Therapeutic Horseback Riding:

In my professional opinion, this patient is able to receive therapeutic horseback riding instruction under appropriate supervision at REINS Therapeutic Horsemanship Program

Physician's Signature _____ Date _____

Physician's Name _____ Phone _____

Office Address _____

Parent/Guardian Signature _____ Date _____



THERAPIST RECOMMENDATION FORM

If student is currently seeing a physical, occupational or speech therapist, please have them fill out this form and/or attach a recent evaluation.

Name of Participant _____ Birthdate: _____

Diagnosis: _____

Current Therapy: _____

Evaluations Used: _____

Short Term Goals:

Long Term Goals:

Objectives: _____

Areas for Improvement: _____

Areas of Strength: _____

Precautions/Contraindications: _____

Cue Style (verbal/physical prompts): _____

Other: _____

Therapist Signature _____ Date _____

Parent Signature _____ Date _____



RELEASE OF LIABILITY AGREEMENT

Name of Participant: _____ Name of Guardian: _____

Address: _____ City & Zip _____

Telephone Number: _____

Emergency Contact: _____

REINS Therapeutic Horsemanship Program is professionally organized and thoughtfully supervised. All staff, volunteers, and horses have been carefully selected. Safety equipment is used for all riders because horseback riding is a risk exercise.

No participant can be accepted into REINS program until a parent or guardian has signed this form or if the rider is of legal age, he/she may sign. Therapeutic riding and Equine Assisted Learning instruction will be under strict supervision and although every effort will be made to avoid any accident, NO LIABILITY can be accepted by the organization, or any persons connected with the organization.

The undersigned as self or parent/guardian of said minor _____, hereby agrees to hold harmless and indemnify REINS, its officers, trustees, agents, employees, volunteers, representatives, and successors from all manner of liability, loss, costs, claims, demands and damages of any kind and nature whatsoever, which the undersigned may now or in the future have against the said facility.

I, _____ (participant/volunteer), am aware of the risks of contracting/spreading communicable diseases/viruses while participating in face-to-face services from REINS Therapeutic Horsemanship Program. I agree to cancel my session, should I exhibit or have been in contact with someone who has presented with illness symptoms. REINS will engage in regular cleaning/sanitization of horse tack, grooming supplies, office and gathering areas to reduce the risk of spread of communicable diseases. I agree to follow these guidelines and hold harmless all individuals associated with or through my services acquired from REINS Therapeutic Horsemanship Program.

Date: _____ Signed: _____



AUTHORIZATION FOR MEDICAL TREATMENT

Name of Participant: _____ Name of Guardian: _____

Participant's Date of Birth _____ Current Diagnosis _____

Current Medications _____ Allergies to Food/Medications _____

Date of Last Tetanus Shot _____ Any special Instructions _____

In the event, that emergency medical treatment is required due to an illness or injury during a therapeutic riding/Equine Assisted Learning session, I authorize REINS to:

1. Call emergency medical help and consent to any necessary treatment that may include transportation, x-ray examination, surgery, medication, or hospitalization.
2. Release participant records upon request of authorized emergency medical personnel if needed. It is understood that every effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Consent Signature: _____ Date: _____

Print Name and Relationship: _____

Telephone numbers where emergency contacts can be reached:

Phone Number: _____

Relation to participant: _____

Phone Number: _____

Relation to participant: _____



INFORMATION AND RESEARCH DATA RELEASE FORM

REINS Therapeutic Horsemanship Program may receive requests from outside sources for release of information and/or data for participants, staff, and volunteers. The outside sources may include other centers, educators, judicial officers, other therapists/medical practitioners, or caseworkers. REINS considers ALL participant information as confidential and will be treated as such. Release of personal information will only be conducted with written consent from the participants, staff, and volunteers of REINS Therapeutic Horsemanship Program. Those whose information is requested from an outside source will have the opportunity to deny this request in writing.

Data obtained from evaluations both formal/informal while said person participates with REINS in any capacity, can be used by REINS and/or PATH Intl. for grant reporting and research in the field of equine assisted services.

Please check desired boxes below and sign/date:

<input type="checkbox"/>	I agree to consent to release participant information to other parties as explained above
<input type="checkbox"/>	I DO NOT agree to consent to release participant information to other parties as explained above
<input type="checkbox"/>	I agree to consent to release of research data to other parties as explained above
<input type="checkbox"/>	I DO NOT agree to consent to release or research data to other parties as explained above

Date: _____

Signed: _____



PHOTO/MEDIA RELEASE FORM

REINS Therapeutic Horsemanship Program (and/or PATH International) uses photographs or video of participants and/or their families for use in marketing materials, grants, press releases and social media. As a participant in any capacity with REINS Therapeutic Riding Program, you have the right to consent/not consent to the use of photos/media in any form.

Please check desired box below & sign/date:

<input type="checkbox"/>	I agree to consent to use of photos/video as explained above
<input type="checkbox"/>	I DO NOT agree to consent to use of photos/video as explained above

Date: _____

Signed: _____