To Our New Riders: WELCOME

To the Monmouth County Park System's SPUR sponsored therapeutic horseback riding program. Enclosed you will find the paperwork you will need to enroll in our program, which is held at the Monmouth County Park System's Sunnyside Equestrian Center:

- **New Student Application**
- **Physician's Medical Form**

The application and medical forms should be completed and returned **together.**
Do not send payment at this time.

The session dates and application deadlines for each 2010 riding session are given below. Those applications postmarked after the deadline will remain on file for the next available session.

	2010 Session Dates	**Applications must be postmarked by**
Winter	February 22-April 17	December 4, 2008
Spring	May 3-June 26	March 5, 2009
Summer	July 12-September 3	May 14, 2009
Fall	September 20- November 13	July 30, 2009

Please return your paperwork to: Monmouth County Park System Equestrian Division
805 Newman Springs Road
Lincroft, New Jersey 07738
Att: Pat Bernstein

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- The fee for each eight week SPUR session is $328. *Do not send payment at this time*.
- Upon receipt of your completed application, you will be placed on our SPUR database and will receive availability and payment forms for the next available session..
- You will be scheduled for a specific day and time for each session, based on availability information you provide to us.
- In some cases, our staff may ask to schedule a meeting with a prospective rider to better plan a program for that individual.
- Financial aid scholarships are available. Please download an application from our website: www.spuronline.org or call Sunnyside Equestrian Center at 732-224-1367 to request an application.
- Scheduling is done on a first come, first served basis. Lessons fill up quickly, so it is important to return availability and payment forms in a timely manner.
- Availability and payment forms must be returned by mail, as we use their postmark to determine scheduling order.
- Student medicals must be renewed by your physician each year; you will be notified of the need to update your paperwork in ample time to allow you to have your medical completed.

FOR OFFICE USE ONLY-ID

Date Received: _______
#: _______

SPECIAL PEOPLE UNITED TO RIDE
MONMOUTH COUNTY PARK SYSTEM

805 Newman Springs Road, Lincroft, NJ 07738-1695
(732) 224-1367

NEW STUDENT APPLICATION

Please complete this form carefully and in detail. The more information we have, the better we can serve you.

Applicant's Name: ____

Address: ____

City: ______________________ State: ______________ Zip: ___________

Telephone: (day) ____________________ (evening) ____________________

Parent/Guardian Name: ____

Phone: ____

Date of Birth: ___________ Age:________ Height: _________ Weight: _________

Disability: ____

History of Disability (onset):____

Ambulatory status: Independent____ Walks with assistance______ Crutches_____Wheelchair_____

If wheelchair is checked, can student sit unsupported with head control? Yes______ No________

History of Seizures: Yes________ No______ Date of last seizure:_________________

Applicant's Physician: ____________________ Phone: ______________________

Applicant's Therapist: ____________________ Phone: ______________________

Name of school or day program (if appropriate): ______________________________

Height and weight are critical for the selection of an appropriate therapy horse.
NO APPLICATIONS WILL BE CONSIDERED THAT ARE RETURNED INCOMPLETE.
This will not only delay the application process but may jeopardize placement into a desired riding session.

Medical History

Medication: ____

For what condition(s): ____

Administration schedule: ____

Restrictions: ____

Any Vision Deficits: _______________Corrected with glasses?_________________

Other relevant information: (Check) ___ Asthma ___ Diabetes ___ Skin Irritations

___ Dizziness/Headaches ___ Allergies ___ Heat Exhaustion ___ Sunburn

GENERAL BACKGROUND INFORMATION

Cognitive Level: ____

Able to understand language: Yes______ No_________

Able to express self verbally: Yes______ No_________

Psychosocial concerns (emotional/social patterns): ___________________________

Are you or the participant's current day program using any behavior modification program? Yes_____ No_________

Does participant have any fears? Yes ___ No ___

Comments: ____

Previous riding experience: ____

When: ____________________Where:_________________________________

Please provide family and/or client concerns, goals and any other information you would

like us to know:____

____

____

____

____

Monmouth County Park System and Special People United to Ride
805 Newman Springs Road
Lincroft, NJ 07738-1695
(732) 224-1367

Dear Physician:

Your patient, ____ (participant's name) is interested in participating in supervised equestrian activities.

In order to safely provide this service, our operating center requests that you complete/update the attached Medical History and Physician's Statement form. Please note that the following condition may suggest precautions and contradiction to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

ORTHOPEDIC

Atlantoaxial Instability – include neurological symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis
Ossification
Joint subluxations/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

NEUROLOGIC

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

OTHER

Age – under 4 years
Indwelling Catheters
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown

MEDICAL PSYCHOLOGICAL

Allergies
Animal Abuse
Physical/Sexual/Emotional/Abuse
Blood Pressure
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the operating center at the address/phone indicated above.

Sincerely,

Pat Bernstein

Pat Bernstein
Equestrian Program Coordinator

Participant's Medical History & 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 Precaution/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 Atlantoaxial Instability: ____

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Y	N	Comments
Allergies			
Auditory			
Balance			
Cardiac			
Cognitive			
Circulatory			
Emotional/Psychological			
Immunity			
Integumentary/Skin			
Learning Disability			
Neurologic			
Muscular			
Orthopedic			
Pain			
Pulmonary			
Speech			
Tactile Sensation			
Visual			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name/Title
: ____ MD DO NP PA Other _____________
Signature: ____ Date: ___________________
Address
: ____
Phone: ( )________________ License /UPIN Number: _________________________________

Monmouth County Board of Recreation Commissioners
(Monmouth County Park System)
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 the agency, I authorize the Monmouth County Park System to:

1. Secure and retain medical treatment and transportation if needed.
2. Release participant's records upon request to the authorized individual or agency involved in the medical emergency treatment.

Participant's Name: ____ Phone: __________________________

Address: ____

In the event I cannot be reached, contact: ______________________________ Phone: _________________

Contact: ______________________________ Phone: _________________

Physician's Name: ____

Preferred Medical Facility: ____

Health Insurance Company: ___________________________________Policy #: ________________________

ALLERGIES/MEDICAL CONDITIONS/MEDICATIONS

____

CONSENT PLAN

I do give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. This provision will only be invoked if the person listed below is unable to be reached.

Date: _______________ Consent Signature: ____
Participant, Parent/Legal Guardian

____
Parent/Legal Guardian

BOTH PARENTS OR LEGAL GUARDIANS MUST SIGN THIS FORM

Print Name: ____ Phone: ______________________

Address: ____

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in the case of illness or 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:

____

____

Date: _______________ Non-Consent Signature: ____
Participant, Parent/Legal Guardian

____
Parent/Legal Guardian

BOTH PARENTS OR LEGAL GUARDIANS MUST SIGN THIS FORM

Print Name: ____ Phone: ______________________

Address: ____

MONMOUTH COUNTY BOARD OF RECREATION COMMISSIONERS
(MONMOUTH COUNTY PARK SYSTEM)
RELEASE FORM

LIABILITY RELEASE:

_________________________________ (Participant's Name) would like to participate in the therapeutic horseback-riding program of the Monmouth County Board of Recreation Commissioners. I acknowledge the risks and potential for risks of horseback-riding. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby for myself and for ____________________________ (Participant's Name), intending to be legally bound, for ourselves and our heirs and assigns, executors or administrators, waive and release forever all claims for damages against the County of Monmouth, the Monmouth County Board of Recreation Commissioners, its Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in this horseback-riding program.

Date: _______________________ Signature: ____
Participant or Parent/Legal Guardian

Signature: ____
Parent/Legal Guardian

BOTH PARENTS OR LEGAL GUARDIAN MUST SIGN THIS FORM

PHOTO RELEASE:

_____ I do not wish to have my child photographed. (No signature required if this option is checked.)

_____ I hereby consent to and authorize the use and reproduction by the Monmouth County Park System of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.

Date: _______________________ Signature: ____
Participant or Parent/Legal Guardian

Signature:____
Parent/Legal Guardian

BOTH PARENTS OR LEGAL GUARDIAN MUST SIGN THIS FORM

Would you be interested in having your child *featured* in a S.P.U.R. newsletter or other periodicals?

Yes _____ No ____