Welcome to the Monmouth County Park System’s SPUR sponsored therapeutic horseback riding program. Enclosed you will find the paperwork you 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 must be completed and returned together. Incomplete applications will be returned to you.

The session dates and application deadlines for each 2018-2019 riding session are given below. Those applications postmarked after the deadline will remain on file for the next available session.

<table>
<thead>
<tr>
<th>Session dates</th>
<th>Applications must be postmarked by</th>
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<tbody>
<tr>
<td>Fall 2018</td>
<td>September 15 – November 10, 2018</td>
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<tr>
<td>Inter session</td>
<td>November 26, 2018 – February 2, 2019</td>
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<tr>
<td>Winter 2019</td>
<td>February 18 – April 13, 2019</td>
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<tr>
<td>Spring 2019</td>
<td>April 26 – June 24, 2019</td>
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<tr>
<td>Summer 2019</td>
<td>July 8, 2019 – August 31, 2019</td>
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</table>

Please return your paperwork to:
Monmouth County Park System Equestrian Division
805 Newman Springs Road
Lincroft, New Jersey 07738
Att: Jackie West, Program Director

The fee for each eight week SPUR session is $354. Do not send payment at this time.

Upon receipt of your completed application, you will be placed in our SPUR database and will receive availability and payment forms for the next available session.

You will be scheduled for a specific date and time for each session, based on the availability information you provide to us. Availability and payment forms must be returned by mail or dropped off in the office.

Scheduling is done on a first come, first served basis. Lessons fill up quickly, so it is important to return forms in a timely manner.

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 call Sunnyside Equestrian Center at 732-224-1367, extension *#, to request an application.

Student medical forms 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 forms completed.
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) _________________________

E-mail: ________________________________________________________________

Parent/Guardian Name: ___________________________________________________

Phone: ________________________________________________________________

Date of Birth: __________________   Age: ______  Height: _______  Weight: ________  
(Necessary to help us choose an appropriate horse for him/her to ride)

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): _______________________________

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 ___

If yes, please describe the fear(s) and the participant’s response to them:  ___________
______________________________________________________________________
______________________________________________________________________

MANDATORY:  How does the participant respond to feelings of frustration and/or
anger? What coping mechanisms help him/her deal with these challenges?
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
Monmouth County Park System and Special People United to Ride  
805 Newman Springs Road  
Lincroft, NJ 07738-1695  
(732) 224-1367, ext. 3#

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

**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

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

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 program director at the address/phone indicated above.

Sincerely,

Jackie West  
Program Director
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:

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<th></th>
<th>Y</th>
<th>N</th>
<th>Comments</th>
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<td>Allergies</td>
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<td>Auditory</td>
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<td>Immunity</td>
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<td>Integumentary/Skin</td>
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<tr>
<td>Learning Disability</td>
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<td>Neurologic</td>
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<td>Other</td>
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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

Participan, 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

Participant, 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 SPUR newsletter or other periodicals?

Yes _____   No _____
Mandatory

Weight Disclosure

Must be filled out by participant’s physician

Weight Policy

In relation to horse health and safety, Special People United to Ride imposes a ruling on weight allowed on the herd of horses currently being utilized in our program.

In general and according to most published pieces a horse is able to carry a percentage of its weight depending on the breed, age, and current fitness without causing pain or long lasting ill effects over a period of time.

At this time this means our riders need to be below a certain weight in order to safely participate in our program.

Exceptions can be made at the total discretion of our trained staff and expert horse health care managers at Sunnyside Equestrian center if;

a) The rider’s ability to be balanced and in correct position can help the horse stay sound and stable.

b) The rider is able to ride independently so volunteers and side walkers will not be put in an unsafe position.

c) The rider can work from the ground for half hour lesson depending on whether they can walk/stand independently or with little assistance.

Rider’s Name: __________________________________________________________

Rider’s Height: _________________________   Weight: _________________________

Physicians Signature: ____________________________________________________