

SUNCATCHER

Therapeutic Riding Academy, Inc.
PO Box 3975
Rapid City, SD 57709
1-605-673-2935 Fax 605 673-4747
SunCatcherTRA@aol.com
www.suncatchertra.org



FOR OFFICE USE ONLY:		Rec'd
Pt 1 (Info)	Ref by:	
Pt 2 (Health)	Rider: New Current Past	
Pt 3 (Rel's)	Data Entry:	
Pt 4 (Phys)	CS SpS DB Sch'd Conf'd	

Both Part 1 and 2 and Health History must be completed and mailed to our office for Registration.

In order to assure the best possible experience, we need to know as much as possible about each prospective person, therefore, all parts of this application (Part 1 and 2) must be completed. The more we know about each person before he/she arrives enables us to be better prepared to care for each person. Please do not hesitate to include any information which you feel may help us. Thank you for your cooperation.

APPLICATION - PART 1

Please Print or Type: E-Mail _____ Date: _____

Name _____
last first middle

Address _____
street city state zip

Telephone _____ County of birth _____ County of Residence _____

Age _____ Date of Birth _____ Height _____ Weight _____ Male Female

Applicant's disability _____ Age of Onset _____

Check type of living situation: Residential Facility _____ Private Home _____
Facility name (if applicable)

Facility Contact person (if applicable) _____ Facility Telephone () _____

Facility Address _____
street city state zip

If applicant lives outside of private home, what is the staff to client ratio? _____

Applicant's Employer / School _____ Telephone () _____

Address _____
street city state zip

Parent / Legal Guardian _____ Relationship to Applicant _____

Telephone Home () _____ Alternate # () _____

Address _____
street city state zip

Parent / Legal Guardian _____ Relationship to Applicant _____

Telephone Home () _____ Alternate # () _____

Address _____
street city state zip

Parent/Legal Guardian Work Address _____ # () _____

Address _____
street city state zip

Parent/Legal Guardian Work Address _____ # () _____

Address _____
street city state zip

Session(s) Desired 1ST CHOICE _____ 3RD CHOICE _____

Please list session preference 2ND CHOICE _____ 4TH CHOICE _____

GOALS

What would the applicant like to accomplish? _____

Name of person filling out application form _____

Relationship to Applicant: _____

How did you hear about the program? _____
 Has the applicant ever attended SunCatcher Therapeutic Riding Academy? yes no When? _____
 Certification Level _____ Has the applicant ever been involved with therapeutic riding? yes no
 If yes, describe experience _____
 Has the applicant ever had any experience or exposure to a horse? yes no If yes, describe experience _____

Emergency Contact and Consultant

In the event that a parent/guardian cannot be reached, who should be contacted regarding medical care or other issues.
 Name _____ Relationship _____ Telephone () _____
 Name _____ Relationship _____ Telephone () _____

Is the applicant covered by MA?	MA #	Medicare?	Medicare #
If applicant is covered under MA, does applicant have any other health insurance coverage, please list:			
Insurance company	Policy #	Policy Holder	
If applicant is not covered by MA or Medicare, please list: Insurance company			
Policy #	Policy Holder		

Programs Offered - See Fee Schedule, Choose Program(s) & Sign Below

Please check the program(s) in which applicant wishes to be enrolled; we will call to schedule riding time:

- Equestrian Special Olympic Program - Equestrian Show Training & Area Show (Spring Term)
- Hippotherapy Facilitation (Facilitates Individual Sessions with Therapist - PT, OT, ST, Psycho-Therapist)
- Rainbow Therapeutic Program - Progressive Therapeutic Equestrian Education & Activity Program (Fall Term)
- Rainbow Enrichment Program - Progressive Equestrian Education & Volunteer Program (Youth Volunteer Riders)
- Special Summer Program - 3 Days Consecutive 3-hr Themed Program Pony Week Rodeo Week
- Equine Experiential Activities - Group Sessions, involving Horse + Human Interaction - w/your Counselor processing
- Recreational Therapeutic Riding - Assisted Riding Program, with Trail, Playdays & Parades (Summer Term)

I Will: Pay in Full per Session or I Have Indicated my Pymt choices on the Enrollment Form
 I have Included an Initial Payment of \$_____ to secure Enrollment Please Bill Me



Signature _____



Date _____

Ridership Grant Information

If you can pay only part of the fee, please Check Above or contact the SunCatcher Office for a Financial Eligibility Application Form. We ask that each rider commit to covering at least part of the fee and make an attempt to seek funding from their contacts or philanthropic organizations within their communities (Church or Church Organizations, Fraternal or Civic Organizations, Family Support Services, etc).

Under the IRS mandates of a charity non-profit organization, the Fees charged cover only 1/3 of our costs to provide programming; each rider incurs expenses for the remaining 2/3 (about \$60/hour - considering insurance, feeding the horses year round, operating expenses, etc) that are not covered by the fees. Therefore, each rider is expected to join in our fund-raising efforts to keep this program running. SunCatcher is a grass-roots, community based, mostly volunteer program organized and run by a group of dedicated individuals for the benefit of our participants. SunCatcher receives NO Government funding; Riderships are partially dependent on fundraising efforts.

Thank you for your involvement and support on behalf of our riders!

Please send me a Ridership Application Form

To support SunCatcher Riders, Applicant / Family WILL WILL NOT Help with Fund-Raising Activities.

May we use applicant's name/photo when seeking contributions for our scholarship fund? yes no



signature parent/guardian _____



signature parent/guardian _____

FOR OFFICE USE ONLY: Amount Ridership Grant Approved: \$ _____ Date _____

SunCatcher Therapeutic Riding Academy, Inc.

HEALTH HISTORY & APPLICATION - PART 2

Date: _____

Name: _____ Date of Birth _____ Age _____

Name of Person Filling out Application Form: _____

A physician statement / prescription is needed that indicates this individual's current physical condition. (Refer to Physician's Statement)

Check One: with disability without disability

Mental retardation (describe ability level) _____ Down's Syndrome

For those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result: + -

Diabetes Insulin dependent _____

Allergies

Please check any that apply: no allergies has allergies Specify allergy and describe reaction:

<input type="checkbox"/> hay fever _____	<input type="checkbox"/> Asthma (list any irritants/stimulants) _____
<input type="checkbox"/> food _____	<input type="checkbox"/> drug _____
<input type="checkbox"/> insect bite _____	<input type="checkbox"/> other _____

Seizures Type _____ Frequency _____

Behavior/aura prior to seizure _____

Length of seizure _____ Recovery time/behavior _____

Frequency of seizures _____ Date of last seizure _____

Further disability/condition instructions: _____

Are emergency measures needed to stop seizures? Yes No **If yes, please explain in detail** _____

HEALTH HISTORY

Please indicate current or past problems in the following areas:

Hearing				<input type="checkbox"/> Hearing aids	<input type="checkbox"/> Deaf
Vision				<input type="checkbox"/> Glasses	
Tactile Sensation					
Heart					
Balance					
Breathing					
Digestion					
Elimination					
Circulation					
Pain					
Bone / Joint					
Muscular					
Epilepsy					
Stroke					

Medication What medications are currently being taken, including over-the-counter medications?

Health History & Application - Part 2 - page 2

Check if applicant is subject to the following:

- | | | | | |
|--|--|--|---|-------------------------------------|
| <input type="checkbox"/> sunburn | <input type="checkbox"/> frequent colds | <input type="checkbox"/> dizziness/fainting spells | <input type="checkbox"/> constipation | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> frostbite | <input type="checkbox"/> bronchitis | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> menstrual problems | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> ear infection | <input type="checkbox"/> pneumonia | <input type="checkbox"/> heart attack | <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> infections |
| <input type="checkbox"/> sinus infection | <input type="checkbox"/> emphysema | <input type="checkbox"/> stroke | <input type="checkbox"/> ulcer | <input type="checkbox"/> hernia |
| <input type="checkbox"/> sore throat | <input type="checkbox"/> carry oxygen tank | <input type="checkbox"/> heart murmur | <input type="checkbox"/> hepatitis carrier: | <input type="checkbox"/> Aids |
| <input type="checkbox"/> skin rash | | | type: _____ | |

Special Appliances / Ambulation

Does applicant use a wheelchair? Yes No Long distances only Manual Electric Stroller
 Does applicant need assistance transferring? Yes No Can applicant support weight transferring? Yes No

Does applicant require assistance in walking? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, does applicant use: <input type="checkbox"/> Support from another person <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Crutches	Describe Gait: <input type="checkbox"/> Stable <input type="checkbox"/> Unsteady <input type="checkbox"/> Walks slowly <input type="checkbox"/> Falls easily	Does applicant wear or use? <input type="checkbox"/> Splints <input type="checkbox"/> Prosthesis <input type="checkbox"/> Braces
--	---	---

Is applicant right handed left handed current weight _____ current height _____
 Further special appliances/ambulation instructions: _____

Communication

Method of Communication

Can applicant communicate wants/needs? Yes No Sign Language Communication Board Other
 Does applicant understand and respond to questions? Yes No Can applicant communicate pain? Yes No
 Further communication instructions: _____

Social Interaction Skills

Check those behaviors which apply to applicant:

- | | | | | |
|--|---|--|--|---|
| <input type="checkbox"/> No unusual behavior | <input type="checkbox"/> Physically aggressive towards others/animals | <input type="checkbox"/> Withdrawn/Shy | <input type="checkbox"/> Verbally aggressive | <input type="checkbox"/> Self Injurious |
| <input type="checkbox"/> Physically aggressive towards objects | <input type="checkbox"/> Attaches self to male staff | <input type="checkbox"/> Attaches self to female staff | <input type="checkbox"/> Temper Tantrums | |
| <input type="checkbox"/> Other _____ | | | <input type="checkbox"/> Wanders/runs away _____ | |

Explain any checked behaviors, their frequency, and method of dealing with behavior: _____

Is applicant presently on a behavior modification program? Yes No If yes, attach a copy of the program.
 Does the applicant have an Aversive/Depritive Procedure? Yes No If yes, attach a copy of the program.
 Further instructions: _____

This Health History is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted. Exceptions: _____



Signature of person who has completed this form



Date



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Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____
 Diagnosis: _____
 Past/Prospective Surgeries: _____
 Medications: _____
 Seizure Type: _____
 Shunt Present: Yes No Date of last revision: _____
 Special Precautions/Needs: _____

Mobility: Independent Ambulation Yes No Assisted Ambulation Yes No Wheelchair Yes No

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:

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary / Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

I understand that this individual is considering participating in a supervised equestrian program. I have knowledge of this individual and his/her current medical condition and have reviewed the list of precautions and contraindications on the reverse side of this form and indicated whether these conditions are present.

Name/Title: _____ MD DO NP PA Other: _____

 Date: _____  Signature: _____

Address: _____

Phone: (_____) _____ Licensed / UPIN Number: _____