

<i>THIS SECTION FOR OFFICE USE ONLY</i>		Administrative Coordinator Initial: _____
Date Received: _____	CIVI ID: _____	Application Complete: _____



### PROGRAM APPLICATION & PERSONAL INFORMATION

Name of Applicant: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth (M/D/Y): \_\_\_\_\_

Applying to program\* (check all that apply):  Therapeutic Riding  Grooming  
 Little Britches  Summer Camp  OT/PT Services

\*Appropriateness for SARI's different programs is decided on an individual basis and is best determined by SARI's team of therapists and certified riding instructors in collaboration with the applicant.

Address of Applicant: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Name of Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Guardian Email: \_\_\_\_\_

Contact if other than Guardian (e.g. third party caregiver, group home): \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact Phone: (1) \_\_\_\_\_ (2) \_\_\_\_\_

Please check all that apply:

The applicant has a diagnosed disability/special need. Note: Physician's referral is required for all applicants with special needs *except* those applying to Grooming. Referral is required for application to be complete.

Disability/Special Need(s): \_\_\_\_\_

The applicant does not have a diagnosed disability/special need and is applying for SARI's integrated children's programming (Little Britches or Summer Camp).

The applicant has allergies which are: \_\_\_\_\_

The applicant is currently taking medication (list all): \_\_\_\_\_

Please indicate the applicant's height (feet/inches): \_\_\_\_\_, and weight\* (lbs): \_\_\_\_\_

*\*Note: participation in horseback riding may be limited if the applicant exceeds 170lbs.*

I hereby certify the information provided on this application form is accurate and grant the applicant permission to receive instruction at SARI Therapeutic Riding.

Print Name (Parent/Guardian): \_\_\_\_\_ Signature: \_\_\_\_\_

Print Name (Applicant >18 Years): \_\_\_\_\_ Signature: \_\_\_\_\_

## PROGRAM INFORMATION FOR APPLICANTS

SARI Therapeutic Riding provides opportunities for people with special needs to move towards greater independence and freedom through their connection with horses. SARI offers five programs to include participants of all levels and abilities.

Program	Session Structure	Details on Applying to Program
<p style="text-align: center;"><b>Therapeutic Riding</b></p> <p style="text-align: center;"><i>Horseback riding lessons are specialized to meet each rider's physical, social, communication and independence goals.</i></p>	<p style="text-align: center;">30 minutes, once per week</p> <p style="text-align: center;">Three sessions: Fall, Winter, Spring</p>	<ol style="list-style-type: none"> <li>1. Complete "Program Application &amp; Personal Information"</li> <li>2. Complete "Physician's Referral"</li> <li>3. Submit both documents to the SARI office to consider your application complete.*</li> </ol>
<p style="text-align: center;"><b>Grooming</b></p> <p style="text-align: center;"><i>Promotes social interaction on the ground through grooming horses and learning horsemanship skills.</i></p>	<p style="text-align: center;">60 minutes, once per week</p> <p style="text-align: center;">Three sessions: Fall, Winter, Spring</p>	<ol style="list-style-type: none"> <li>1. Complete "Program Application &amp; Personal Information"</li> <li>2. Submit document to the SARI office.</li> </ol>
<p style="text-align: center;"><b>Little Britches</b></p> <p style="text-align: center;"><i>A fun-filled integrated program open to children with and without special needs, age 4-12. Participants enjoy crafts, games, songs, and a pony ride.</i></p>	<p style="text-align: center;">Half days (AM or PM)</p> <p style="text-align: center;">One Sunday per month</p> <p style="text-align: center;">Spring (March-June) or Fall (Sept-Dec)</p>	<ol style="list-style-type: none"> <li>1. Complete "Program Application &amp; Personal Information"</li> <li>2. If applicant has a diagnosed special need, complete "Physician's Referral"*</li> <li>3. Submit document(s) to the SARI office. <i>Please include your selection of dates for participation:</i> _____</li> </ol>
<p style="text-align: center;"><b>Summer Camp</b></p> <p style="text-align: center;"><i>An exciting day camp for kids age 6 to 18. Participants enjoy horseback riding lessons, crafts, guest speakers, theme days and horsemanship activities.</i></p>	<p style="text-align: center;">Full days, 9am to 4pm</p> <p style="text-align: center;">Monday to Friday, July and August</p>	<ol style="list-style-type: none"> <li>4. Payment and application are required to hold spot.</li> </ol>

\*Applicants with special needs will be contacted for assessment by SARI's team of therapists and certified riding instructors to determine suitability for participation in programs. This process costs \$85 (Therapeutic Riding only) and takes up to 60 minutes and includes a portion with horses. This process is mandatory to optimize safety and participant's experience while at SARI. *The \$85 assessment fee is non-refundable.*

**THIS SECTION FOR OFFICE USE ONLY & ADMINISTRATIVE COORDINATOR NOTES:**

Applicant choice of Little Britches (circle):      SPRING      FALL       \$ Received      Staff Initials: \_\_\_\_\_

Applicant choice of Camp Week(s) (circle): 1 2 3 4 5 6 7 8 9       \$ Received      Staff Initials: \_\_\_\_\_

**Notes:**

**SARI THERAPEUTIC RIDING - INFORMED WAIVER AND CONSENT**

**THIS FORM MUST BE READ AND SIGNED BY EVERY PARTICIPANT, VOLUNTEER AND/OR PARENT/ GUARDIAN WHO WISHES TO PARTICIPATE (OR HAVE THEIR DEPENDENT PARTICIPATE) IN A PROGRAM OR EQUESTRIAN EVENT OF SARI THERAPEUTIC RIDING.**

PROGRAM PARTICIPANT    VOLUNTEER                      EVENT PARTICIPANT                      OTHER

**ELEMENTS OF RISK**

Horseback riding and other activities involving being in close proximity to horses or horse facilities involve an element of risk. Injuries may occur while participating in activities while riding, handling or being in close proximity to a horse. The following list includes, but is not intended to be exhaustive, examples of the types of injury which may result from participating at SARI Therapeutic Riding:

**Fall from horse                      Bite from horse                      Kick from horse                      Stepped on by horse**

The risk of sustaining these or other types of injuries result from the nature of the activity and can occur without any fault of the participant, volunteer, fee paying participant, SARI Therapeutic Riding, its employees/agents, or the facility where the activity is taking place. By choosing to take part in this activity, you are accepting the risk that you or your dependent may be injured.

The risk of an injury occurring can be reduced, but not eliminated, by carefully following instructions at all times while engaged in the activity or while in proximity to horses or horse facilities.

If you choose to participate or choose to have your dependent participate, you acknowledge and agree that you bear the responsibility for any injury that may occur. SARI Therapeutic Riding does not provide accidental death, disability, dismemberment or medical expense insurance on behalf of the participants or volunteers participating in their programs.

In addition, you acknowledge and accept that there are risks to your horse (or your dependent's horse) and of liability to third parties or property resulting from the conduct and behaviour of that horse. You acknowledge and agree that you shall be solely responsible for all damage or injury to third parties or property that may result from the actions of you, your dependent and such horse.

In addition to the foregoing, you acknowledge and accept that there may be risks to you and your dependent, and even your horse, of contracting an infectious disease, including but not limited to COVID-19, while being in proximity to other people, horses or horse facilities, even where reasonable care is used.

**In exchange for myself, my dependent, or my (or my dependant's) horse being permitted to participate in these SARI activities, I hereby agree:**

- (i) that I acknowledge, accept and assume all risks and responsibilities as set out above for myself, my dependent, and such horse;**
- (ii) that I release, discharge and agree not to make any claims of any kind against SARI Therapeutic Riding, its officers, directors, members, employees, volunteers, guests and any land owners, land holders or other persons making property available to SARI Therapeutic Riding, their respective successors and assigns (collectively, the "Released Parties") for any injury, including death, to myself or to my dependent or such horse arising out of or in relation to my or my dependent's or horse's participation in SARI horseback riding or related activities, and any illness or infectious disease, including COVID-19, contracted by myself or my dependent or horse, and any injury or damage to my or my dependent's horse or property, and for any liability arising as a result of claims for injuries or damages or illness sustained by third parties, and injury or damage to the property of third parties, as a result of the actions of myself, my dependent or my or my dependent's horse, (collectively, the "Released Claims"), whether or not such Released Claims arose as a result of the negligence of any of the Released Parties; and**
- (iii) that I shall indemnify and save harmless the Released Parties, and each of them, from and against any and all claims, demands and/or liabilities arising out of or in relation to my participation or the participation of my dependent or horse in these activities, including without limitation all of the Released Claims, and including without limitation all legal costs incurred by any of them in connection with such claims.**

**ACKNOWLEDGEMENT**

BY SIGNING BELOW, I HEREBY DECLARE THAT I AM OF LEGAL AGE AND I HAVE READ AND FULLY UNDERSTAND AND AGREE TO THE TERMS AND CONDITIONS STATED HEREIN AND THAT IT IS BINDING ON ME, MY EXECUTORS, HEIRS AND ASSIGNS. IF I AM SIGNING AS PARENT/GUARDIAN, I HEREBY DECLARE THAT I HAVE THE LEGAL AUTHORITY TO DO SO. I UNDERSTAND THAT IN PARTICIPATING (OR PERMITTING MY DEDPENDANT TO PARTICIPATE) IN A SARI EQUESTRIAN PROGRAM OR EVENT, I AM ASSUMING ALL RISKS AND RESPONSIBILITIES AS SET OUT ABOVE ASSOCIATED WITH DOING SO.

Print Name of Volunteer/Participant: \_\_\_\_\_ Date: \_\_\_\_\_ Age (if under 18): \_\_\_\_\_

Print Name of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Volunteer/Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**PERMISSION**

I give (name of participant or volunteer) \_\_\_\_\_ permission to participate in the SARI Therapeutic Riding Program or equestrian event.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



**PHYSICAL CONTACT POLICY**

Due to the nature of the work at SARI Therapeutic Riding it is understood that physical contact with the participants by staff, instructors, therapists and trained volunteers is necessary.

Physical contact may include the following:

- Assisting riders when mounting.
- Assisting riders when riding a horse to maintain correct, safe posture and position.
- Assisting riders when dismounting.
- Where necessary to address safety and/or behavioural or other concerns, to quickly physically remove a rider from the horse.

Physical contact is undertaken for the well-being of the participant and is undertaken in the interest of providing a safe environment for all. Any physical contact that is necessary will be undertaken with the utmost discretion.

**I have read, understood and agree to the terms of the policy.**

Print Name of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Volunteer/Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



**PHOTO RELEASE FORM**

I give consent to SARI Therapeutic Riding to publish still and moving photographs taken of the individual named below, for use in SARI’s print, online, and video-based marketing and/or educational materials, as well as other publications. This includes but is not limited to use on SARI posters, social media, newsletter, email communications or for any other use for benefit of the program.

**I ACCEPT**

**I DECLINE**

Print Name of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

***If Volunteer/Participant Under 18***

Print Name of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Note: It is the parent/guardian’s responsibility to notify the office if the status of this consent changes.



**SARI**  
THERAPEUTIC RIDING

Changing Lives  
Stride by Stride

Dear Physician,

Thank you for completing the referral form for your patient to apply to participate in the program at SARI Therapeutic Riding. Your comments will help our therapists and instructors decide on this patient's suitability for riding and help them provide a better quality individualized program for the patient. Where possible, please be specific with your comments. The physician is asked to complete the entire form. For this reason, please stamp the final page of the referral with your office's stamp. If any part of the referral is incomplete or completed by the parent/guardian, the form will be returned to the applicant and they will not be placed onto the wait list. Please take the time to ensure each space is complete.

Please review the list of contraindications and precautions, and consider the ones that may be applicable for your patient. A full index of precautions and contraindications is available on our website at [sari.ca/precautions](http://sari.ca/precautions). If you have any questions or concerns, contact the SARI office.

Horseback riding puts participants with Atlantoaxial Instability (AAI) at an increased risk of injury including but not limited to falling from a height, sudden movements of the equine, the weight of the rider's helmet, or repeated motion of the rider with every stride of the horse. The presence of neurological signs in individuals with AAI is a contraindication for mounted activities; riding is not considered safe until the participant's condition improves. For this reason, and in accordance with PATH Intl. Standards, SARI Therapeutic Riding requires annual medical clearance for all participants with Down Syndrome, and any other participant with a condition that may present AAI.

Upon receiving your referral and other documentation from the applicant, he/she will be booked for an assessment by a Physiotherapist or Occupational Therapist prior to entrance into our program. This evaluation will assess the rider's abilities on and off the horse and determine the appropriateness of the applied for program. The assessment will also determine special requirements and adaptations needed for riding. The rider may be reassessed should it be warranted.

Working with equines is considered a high risk activity; therefore, the highest standards of safety and therapeutic riding instruction are maintained as per the Professional Association of Therapeutic Horsemanship International.

SARI offers three sessions per year and classes run weekly for 30-60 minutes, depending on the size and ability of the class participants. Depending on the level of the ability of rider, he/she may have a volunteer lead the horse and may have one or two volunteers walk beside the horse to provide physical support. The majority of classes are walk-trot or walk only. Please consider the implications of the horse's gait (i.e. smooth, choppy, animated) on your patient when on horseback, as well as the potential impact of a rider fall from an equine between 4-7 feet from the ground before deeming this an appropriate activity for the applicant.

Thank you again for completing the referral form. If you have any questions about your patient's participation in the program or have other questions about SARI and therapeutic equine programs in general, please do not hesitate to call the office at 519-666-1123.

Sincerely,

Lisa Citton-Battel  
Interim Executive Director

# SARI THERAPEUTIC RIDING

## CONTRAINDICATIONS AND PRECAUTIONS FOR THERAPEUTIC RIDING

The following conditions may represent precautions or contraindications to therapeutic horseback riding if present in potential participants. Therefore, when completing the physician's referral, please note whether these conditions are present and to what degree. **Full index of precautions and contraindications is available on our website at [sari.ca/precautions](http://sari.ca/precautions).**

- Achondroplasia
- Age-Related Considerations
- Allergies
- Amputations
- Amyotrophic Lateral Sclerosis (ALS)
- Arthritis, including JRA, rheumatoid arthritis
- Arthrogyrosis
- Asthma
- Atherosclerosis
- Attention Deficit Hyperactive Disorder
- Autism Spectrum Disorder
- Autonomic Dysreflexia
- Behaviour and Psychosocial Problems/Conduct Disorder
- Brain Injury/Encephalopathy
- Cancer
- Cerebral Palsy
- Chiari II Malformation
- Childhood Disintegrative Disorder
- Chronic Fatigue Immune Dysfunction Syndrome
- Chronic Obstructive Pulmonary Disease (COPD)
- Communication Disorder
- Cranial Defects
- Cystic Fibrosis
- Degenerative Joint Conditions
- Decubitus Ulcers
- Diabetes
- Dorsal Rhizotomy
- Down Syndrome/Atlantoaxial Instability
- Eating Disorders
- Epilepsy
- Equipment, i.e. feeding tubes, tracheostomies, internal pumps, shunts, catheter, etc.
- Fatigue/Poor Endurance
- Fibromyalgia
- Guillain-Barre Syndrome
- Head/Neck Control
- Heart/Cardiac Conditions
- Hemiplegia
- Hemophilia
- Heterotopic Ossification/Myositis Ossificans
- High Blood Pressure/Hypertension
- Hip Subluxation and Dislocation
- HIV Positive/AIDS
- Hydrocephalus
- Hydromyelia
- Hypertonia/Hypotonia
- Hypochondroplasia
- Hypoxic Ischemia
- Joint Replacement
- Medications, i.e. phototoxicity, photoallergy, anticoagulants, anticonvulsants, antipsychotics, blood thinners, bronchodilators, pain control, etc.
- Migraines/Headaches
- Myelomeningocele
- Myopathy/Muscular Dystrophy/Spinal Muscular Atrophy
- Neuromuscular Disorders/Multiple Sclerosis
- Obesity
- Oppositional Defiant Disorder
- Osteogenesis Imperfecta
- Osteoarthritis
- Osteoporosis
- Osteotomy
- Paraplegia
- Pathologic Fractures
- Peripheral Vascular Disease
- Pervasive Developmental Disorder/PDD-NOS
- Post-Polio Syndrome
- Quadriplegia
- Raynaud's Phenomenon
- Respiratory Compromise
- Rett Syndrome
- Sensory Integrative Disorder/Sensory Processing Dysfunction
- Skin Integrity
- Spina Bifida/Spina Bifida Occulta/Spina Bifida Cystica
- Spinal Cord Injury
- Spinal Curvature – scoliosis, kyphosis, lordosis
- Spinal Fusion/Fixation
- Spinal Instability
- Spinal Muscular Atrophy
- Spinal Orthosis
- Stroke/Cerebrovascular Accident
- Substance Abuse/Drug or Alcohol Dependence
- Surgery (recent)
- Total Hip/Knee Replacement
- Trunk Control

# SARI THERAPEUTIC RIDING PHYSICIAN'S REFERRAL

<b>NAME OF CLIENT</b> Click or tap here to enter text.	<b>DATE OF BIRTH</b> Click or tap here to enter text.
<b>WEIGHT</b> <i>*Participation in horseback riding may be limited above 170lbs.</i> Click or tap here to enter text.	<b>HEIGHT</b> Click or tap here to enter text.
<b>PRIMARY DIAGNOSIS</b> Click or tap here to enter text.	<b>DATE OF ONSET</b> Click or tap here to enter text.
<b>SECONDARY DIAGNOSIS OR ASSOCIATIONS</b> Click or tap here to enter text.	<b>DATE OF ONSET</b> Click or tap here to enter text.

**PLEASE CIRCLE APPROPRIATE RESPONSE AND COMMENT SPECIFICALLY AND AS NECESSARY**

<b>AUDITORY IMPAIRMENTS</b>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	<b>IF YES, BE SPECIFIC:</b> Click or tap here to enter text.
<b>SPEECH IMPAIRMENTS</b>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	<b>IF YES, BE SPECIFIC (i.e. verbal, non-verbal, other):</b> Click or tap here to enter text.  <b>MODE OF COMMUNICATION (i.e. PECS, ASL):</b> Click or tap here to enter text.
<b>VISUAL IMPAIRMENTS</b>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	<b>IF YES, BE SPECIFIC:</b> Click or tap here to enter text.
<b>BEHAVIOURAL CONCERNS</b>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	<b>IF YES, BE SPECIFIC: (as to how the applicant's behaviour may affect their level of risk around horses, i.e. flight risk, aggression, lack of fear, etc.)</b>  Click or tap here to enter text.
<b>MENTAL HEALTH CONCERNS</b>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	<b>IF YES, BE SPECIFIC:</b> Click or tap here to enter text.
<b>CIRCULATORY IMPAIRMENTS</b>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	<b>IF YES, BE SPECIFIC:</b> Click or tap here to enter text.
<b>ABNORMAL SENSATION</b>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	<b>IF YES, BE SPECIFIC:</b> Click or tap here to enter text.

<b>DOWN SYNDROME &amp; ATLANTOAXIAL INSTABILITY (AAI)</b>	<p><b>A NEUROLOGIC EXAM HAS DETERMINED THAT NEUROLOGIC SIGNS OF ATLANTOAXIAL INSTABILITY OR FOCAL NEUROLOGIC DISORDER ARE:</b>  <input type="checkbox"/> Present                                         <input type="checkbox"/> Absent</p> <p><i>Only for those with a diagnosis of Down Syndrome (or other diagnosis that may present AAI). Annual medical clearance by a physician indicating the absence of neurological signs of AAI is required for participants with this diagnosis. The presence of neurological signs in individuals consistent with AAI is a contraindication for mounted activities; riding is not safe until the participant's condition improves.</i></p>			
<b>INCONTINENCE</b>	<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>	Click or tap here to enter text.	
<b>DIABETIC</b>	<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>	Click or tap here to enter text.	
<b>SEIZURES</b>	<p><i>Although seizures are not always contraindicated to therapeutic riding, we do need to take extra safety precautions in case a rider were to have a seizure while mounted on a horse. It is beneficial for us to have full knowledge of the seizures they experience so our program therapists can determine eligibility for the program.</i></p> <p><i>Please consider the potential impact on your patient of a rider fall from an equine between 4-7 feet from the ground before deeming this an appropriate activity for the applicant.</i></p>			
<b>NONE</b> <input type="checkbox"/>		<b>ABSENCE</b> <input type="checkbox"/>	<b>PARTIAL COMPLEX</b> <input type="checkbox"/>	<b>TONIC CLONIC</b> <input type="checkbox"/>
<b>ARE SEIZURES CONTROLLED BY MEDICATION?</b> <b>NO</b> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/>				
<b>DATE OF LAST SEIZURE:</b> Month _____ Year _____				
<p><b>DO THE SEIZURES HAPPEN AT A SPECIFIC TIME EACH DAY? IF YES, PLEASE DESCRIBE:</b>  Click or tap here to enter text.</p>				
<p><b>IS THERE ANY OTHER INFORMATION WE SHOULD BE AWARE OF? Please consider triggers, changes to expect during seizure, duration, when it's a medical emergency, special instructions, etc. If a seizure plan is available, please attach to completed referral.</b>  Click or tap here to enter text.</p>				



<b>HIP SUBLUXATION OR DISLOCATION</b>	<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>	<b>IF YES, BE SPECIFIC:</b> Click or tap here to enter text.
<b>CO-ORDINATION OF UPPER EXTREMITIES</b>	<input type="checkbox"/> <b>NORMAL</b>	<input type="checkbox"/> <b>ABNORMAL</b>	<input type="checkbox"/> <b>GROSSLY ABNORMAL</b>
<b>CO-ORDINATION OF LOWER EXTREMITIES</b>	<input type="checkbox"/> <b>NORMAL</b>	<input type="checkbox"/> <b>ABNORMAL</b>	<input type="checkbox"/> <b>GROSSLY ABNORMAL</b>
<b>MUSCLE TONE – UPPER EXTREMITIES</b>	<input type="checkbox"/> <b>NORMAL</b>	<input type="checkbox"/> <b>HIGH TONE</b>	<input type="checkbox"/> <b>LOW TONE</b>
<b>MUSCLE TONE – LOWER EXTREMITIES</b>	<input type="checkbox"/> <b>NORMAL</b>	<input type="checkbox"/> <b>HIGH TONE</b>	<input type="checkbox"/> <b>LOW TONE</b>
<b>MUSCLE TONE – TRUNK &amp; NECK</b>	<input type="checkbox"/> <b>NORMAL</b>	<input type="checkbox"/> <b>HIGH TONE</b>	<input type="checkbox"/> <b>LOW TONE</b>
<b>SITTING BALANCE STATIC</b>	<input type="checkbox"/> <b>GOOD</b>	<input type="checkbox"/> <b>FAIR</b>	<input type="checkbox"/> <b>POOR</b>
<b>SITTING BALANCE DYNAMIC</b>	<input type="checkbox"/> <b>GOOD</b>	<input type="checkbox"/> <b>FAIR</b>	<input type="checkbox"/> <b>POOR</b>
<b>STANDING BALANCE STATIC</b>	<input type="checkbox"/> <b>GOOD</b>	<input type="checkbox"/> <b>FAIR</b>	<input type="checkbox"/> <b>POOR</b>
<b>STANDING BALANCE DYNAMIC</b>	<input type="checkbox"/> <b>GOOD</b>	<input type="checkbox"/> <b>FAIR</b>	<input type="checkbox"/> <b>POOR</b>

<b>MEDICATIONS</b>	<b>PLEASE SPECIFY, including side effects:</b> Click or tap here to enter text.	
<b>RELEVANT SURGERIES AND DATES</b>	<b>PLEASE SPECIFY:</b> Click or tap here to enter text.	
<b>ASSISTIVE DEVICES, BRACES, SPINAL RODS OR FUSION</b>	<b>PLEASE SPECIFY:</b> Click or tap here to enter text.	
<b>SHUNTS</b>	<input type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>YES</b>	<b>IF YES, BE SPECIFIC:</b> Click or tap here to enter text.
<b>KNOWN ALLERGIES</b>	Click or tap here to enter text.	
<b>DATE OF LAST TETANUS</b>	Click or tap here to enter text.	
<b>COMMUNICABLE DISEASES</b>	<input type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>YES</b>	<b>IF YES, BE SPECIFIC:</b> Click or tap here to enter text.
<b>DOWN SYNDROME &amp; RHEUMATOID CERVICAL SPINE X-RAYS (see contraindications)</b>	<b>YEAR &amp; DETAILS (attach report - mandatory)</b> Click or tap here to enter text.	
<b>FLEXION/EXTENSION X-RAYS REQUIRED (see contraindications)</b>	<b>YEAR &amp; DETAILS (attach report - mandatory)</b> Click or tap here to enter text.	
<b>AUTISM SPECTRUM DIAGNOSIS</b>	<b>DESCRIBE ASSOCIATED BEHAVIOURS:</b> Click or tap here to enter text.	

<b>CRITERIA FOR INCLUSION IN HIPPO THERAPY PROGRAM</b>	<b>CHECK ONE:</b> <input type="checkbox"/> The applicant is <i>ABLE</i> to sit, unaided, on a hard surface for 30 sec. <input type="checkbox"/> The applicant is <i>UNABLE</i> to sit, unaided, on a hard surface for 30 sec.
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**PLEASE COMMENT ON HOW THE SPECIFIC PROGRAM (RIDING, GROOMING, SUMMER CAMP, ETC.) MAY BENEFIT THE APPLICANT:**

Click or tap here to enter text.

<b>HOW OFTEN SHOULD THIS FORM BE UPDATED?</b>	<input type="checkbox"/> <b>YEARLY</b>	<input type="checkbox"/> <b>EVERY 2 YRS</b>	<input type="checkbox"/> <b>EVERY 5 YRS</b>	<input type="checkbox"/> <b>NEVER</b>
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In my opinion, this patient is eligible for the program being applied to at SARI Therapeutic Riding. I understand that this patient will receive an assessment by a physical, occupational therapist. This process will be done to determine suitability for programs with respect to applicant's physical and cognitive abilities and/or limitations in performing exercises and activities around horses.

<b>PHYSICIAN'S NAME (PRINT)</b> Click or tap here to enter text.	<b>PHYSICIAN'S OFFICE STAMP</b>
<b>PHYSICIAN'S SIGNATURE</b>	
<b>DATE</b> Click or tap here to enter text.	

SARI treats all personal information as confidential and does not release it to any other organization. Any information provided may be used to decide on this patient's suitability for riding and help provide a better quality individualized program for the patient.

**Provide form to: SARI Therapeutic Riding, 12659 Medway Road, Arva ON, N0M 1C0**  
**For further information, please contact the SARI office at 519-666-1123 or [office@sari.ca](mailto:office@sari.ca)**