

<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

*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
Therapeutic Riding <i>Horseback riding lessons are specialized to meet each rider's physical, social, communication and independence goals.</i>	30 minutes, once per week Three sessions: Fall, Winter, Spring	<ol style="list-style-type: none"> 1. Complete "Program Application & Personal Information" 2. Complete "Physician's Referral" 3. Submit both documents to the SARI office to consider your application complete.*
Grooming <i>Promotes social interaction on the ground through grooming horses and learning horsemanship skills.</i>	60 minutes, once per week Three sessions: Fall, Winter, Spring	<ol style="list-style-type: none"> 1. Complete "Program Application & Personal Information" 2. Submit document to the SARI office.
Little Britches <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>	Half days (AM or PM) One Sunday per month Spring (March-June) or Fall (Sept-Dec)	<ol style="list-style-type: none"> 1. Complete "Program Application & Personal Information" 2. If applicant has a diagnosed special need, complete "Physician's Referral"* 3. Submit document(s) to the SARI office. <i>Please include your selection of dates for participation:</i> _____ _____
Summer Camp <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>	Full days, 9am to 4pm Monday to Friday, July and August	<ol style="list-style-type: none"> 4. Payment and application are required to hold spot.

*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 \$75 (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 \$75 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

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. 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,

Janine Langley
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.**

- 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

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

PLEASE CIRCLE APPROPRIATE RESPONSE AND COMMENT SPECIFICALLY AND AS NECESSARY

AUDITORY IMPAIRMENTS	NO <input type="checkbox"/>	YES <input type="checkbox"/>	IF YES, BE SPECIFIC: Click or tap here to enter text.
SPEECH IMPAIRMENTS	NO <input type="checkbox"/>	YES <input type="checkbox"/>	IF YES, BE SPECIFIC (i.e. verbal, non-verbal, other): Click or tap here to enter text. MODE OF COMMUNICATION (i.e. PECS, ASL): Click or tap here to enter text.
VISUAL IMPAIRMENTS	NO <input type="checkbox"/>	YES <input type="checkbox"/>	IF YES, BE SPECIFIC: Click or tap here to enter text.
BEHAVIOURAL CONCERNS	NO <input type="checkbox"/>	YES <input type="checkbox"/>	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.) Click or tap here to enter text.
MENTAL HEALTH CONCERNS	NO <input type="checkbox"/>	YES <input type="checkbox"/>	IF YES, BE SPECIFIC: Click or tap here to enter text.
CIRCULATORY IMPAIRMENTS	NO <input type="checkbox"/>	YES <input type="checkbox"/>	IF YES, BE SPECIFIC: Click or tap here to enter text.
ABNORMAL SENSATION	NO <input type="checkbox"/>	YES <input type="checkbox"/>	IF YES, BE SPECIFIC: Click or tap here to enter text.

DOWN SYNDROME & ATLANTOAXIAL INSTABILITY (AAI)	A NEUROLOGIC EXAM HAS DETERMINED THAT NEUROLOGIC SIGNS OF ATLANTOAXIAL INSTABILITY OR FOCAL NEUROLOGIC DISORDER ARE: <input type="checkbox"/> Present <input type="checkbox"/> Absent <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>					
INCONTINENCE	NO <input type="checkbox"/>	YES <input type="checkbox"/>	Click or tap here to enter text.			
DIABETIC	NO <input type="checkbox"/>	YES <input type="checkbox"/>	Click or tap here to enter text.			
SEIZURES	NONE <input type="checkbox"/>	ABSENCE <input type="checkbox"/>	PARTIAL COMPLEX <input type="checkbox"/>	TONIC CLONIC <input type="checkbox"/>	DATE OF LAST SEIZURE Click or tap here to enter text.	
	DESCRIPTION OF SEIZURE – 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. Click or tap here to enter text.					
HIP SUBLUXATION OR DISLOCATION	NO <input type="checkbox"/>	YES <input type="checkbox"/>	IF YES, BE SPECIFIC: Click or tap here to enter text.			
CO-ORDINATION OF UPPER EXTREMITIES	<input type="checkbox"/> NORMAL		<input type="checkbox"/> ABNORMAL		<input type="checkbox"/> GROSSLY ABNORMAL	
CO-ORDINATION OF LOWER EXTREMITIES	<input type="checkbox"/> NORMAL		<input type="checkbox"/> ABNORMAL		<input type="checkbox"/> GROSSLY ABNORMAL	
MUSCLE TONE – UPPER EXTREMITIES	<input type="checkbox"/> NORMAL		<input type="checkbox"/> HIGH TONE		<input type="checkbox"/> LOW TONE	
MUSCLE TONE – LOWER EXTREMITIES	<input type="checkbox"/> NORMAL		<input type="checkbox"/> HIGH TONE		<input type="checkbox"/> LOW TONE	
MUSCLE TONE – TRUNK & NECK	<input type="checkbox"/> NORMAL		<input type="checkbox"/> HIGH TONE		<input type="checkbox"/> LOW TONE	
SITTING BALANCE STATIC	<input type="checkbox"/> GOOD		<input type="checkbox"/> FAIR		<input type="checkbox"/> POOR	
SITTING BALANCE DYNAMIC	<input type="checkbox"/> GOOD		<input type="checkbox"/> FAIR		<input type="checkbox"/> POOR	
STANDING BALANCE STATIC	<input type="checkbox"/> GOOD		<input type="checkbox"/> FAIR		<input type="checkbox"/> POOR	
STANDING BALANCE DYNAMIC	<input type="checkbox"/> GOOD		<input type="checkbox"/> FAIR		<input type="checkbox"/> POOR	
MEDICATIONS	PLEASE SPECIFY, including side effects: Click or tap here to enter text.					
RELEVANT SURGERIES AND DATES	PLEASE SPECIFY: Click or tap here to enter text.					
ASSISTIVE DEVICES, BRACES, SPINAL RODS OR FUSION	PLEASE SPECIFY: Click or tap here to enter text.					

SHUNTS	<input type="checkbox"/> NO <input type="checkbox"/> YES	IF YES, BE SPECIFIC: Click or tap here to enter text.
KNOWN ALLERGIES	Click or tap here to enter text.	
DATE OF LAST TETANUS	Click or tap here to enter text.	
COMMUNICABLE DISEASES	<input type="checkbox"/> NO <input type="checkbox"/> YES	IF YES, BE SPECIFIC: Click or tap here to enter text.
DOWN SYNDROME & RHEUMATOID CERVICAL SPINE X-RAYS (see contraindications)	YEAR & DETAILS (attach report - mandatory) Click or tap here to enter text.	
FLEXION/EXTENSION X-RAYS REQUIRED (see contraindications)	YEAR & DETAILS (attach report - mandatory) Click or tap here to enter text.	
AUTISM SPECTRUM DIAGNOSIS	DESCRIBE ASSOCIATED BEHAVIOURS: Click or tap here to enter text.	
CRITERIA FOR INCLUSION IN HIPPO THERAPY PROGRAM	CHECK ONE: <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.	

PLEASE COMMENT ON HOW THE SPECIFIC PROGRAM (RIDING, GROOMING, SUMMER CAMP, ETC.) MAY BENEFIT THE APPLICANT:

Click or tap here to enter text.

HOW OFTEN SHOULD THIS FORM BE UPDATED?	<input type="checkbox"/> YEARLY	<input type="checkbox"/> EVERY 2 YRS	<input type="checkbox"/> EVERY 5 YRS	<input type="checkbox"/> NEVER
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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.

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