



MACH 1 Rider Package Check List

All of the forms listed below are required to be completed, checked, signed and dated as indicated prior to the start of rider participation and annually thereafter.

To be completed by rider, parent or caregiver by

- 1. Rider package check list
- 2. Rider registration form
- 3. Contact and tuition payment
 - a) Payment, Check Cash On Line
- 4. Mach 1 riders release
- 5. Rose Bowl Riders release
- 6. Confidentiality agreement
 - a) Photo and video release
- 7. Authorization for emergency medical treatment form
- 8. Annual Health History and Contact Information Update Form
- 9. Possible reasons for discharge form
- 10. Rider goal sheet

To be completed by the riders physician

- 11. Letter for the Physician
- 12. Information for Physician (Precautions and Contraindications)
- 13. Rider health history/physician assessment form
 - b) Cervical X-ray results for Atlanto-axial Instability for persons with Down Syndrome (if applicable)
- 14. Physician release

For office use only

Forms	1	2	3	4	5	6	7	8	9	10	11
12	13	14									



Rider Registration

Program Information

Date: _____

Participant Name: _____ Phone: _____

Address: _____

DOB _____ Age _____ Height _____ Weight _____ Gender M F

Primary Diagnosis _____

Secondary Diagnosis _____

Mobility status (walks unassisted, assistive devices, etc) _____

Communication (verbal, non-verbal signs) _____

Behaviors (impulsive, fearful, frustration tolerance) _____

Medications Taken _____

Seizures (if applicable please describe) _____

Limitations _____

Allergies _____

Skin sensitivity _____

Participant's occupation/ school grade level _____

Affiliate Program if applicable _____

Personal Goals (fill in the areas that apply) _____

Physical _____

Cognitive _____

Social/Behavioral _____

Life skills _____

Other _____

Availability for the MACH 1 Program (Check all available times and days)

Wednesday am____ Thursday am____ Thursday pm____ Friday pm____ Saturday am____

Start Date: _____ (Decided at the assessment)



Client Contact and Tuition Information

Participant Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Cell: _____

Email Address: _____

Names of parents/guardian:

Father: _____ Cell: _____ Email: _____

Mother: _____ Cell: _____ Email: _____

Best Emergency Contact: Name: _____

Phone: _____ Cell: _____

Parent occupation and employer:

Father: _____ Work Phone: _____

Mother: _____ Work Phone: _____

How were you referred to Mach1? _____

Program Tuition Payment Details

Please tell us how you will be paying:

Monthly: Individual Lessons \$40.00

4 Monthly Lessons \$140.00

5 Monthly Lessons \$175.00

Check (please make payable to MACH 1)

Pay credit card payment through the moveachildhigher.org website.

Credit Card

I _____ authorize MACH 1 to charge \$_____ to my credit card.

Date: _____

Name on Card: _____ Cardholder signature: _____

Billing zip code: _____ Card Number: _____ Exp.: _____

I understand and agree that all paperwork must be up to date and that all tuition is to be paid prior to the start of each month. Credit card payment will be for one month.

Signature of Rider or Legal Guardian: _____ Date: _____



RELEASE AND HOLD HARMLESS AGREEMENT

MOVE A CHILD HIGHER, INC. (MACH 1) provides therapeutic horseback riding for disabled riders. Horseback riding is a risk exercise, so volunteers and horses are carefully selected and trained and safety equipment is required for all riders.

No student will be accepted for riding instruction and no volunteer, participants accepted for service until this form has been **READ, UNDERSTOOD, COMPLETED AND SIGNED** by the parent(s) or guardian(s) of a minor or by the student or volunteer if of legal age and sound mind.

Although participation in the **MOVE A CHILD HIGHER, INC.** (MACH 1) program is under strict supervision and every effort is made to avoid injury or accident, the undersigned acknowledges the inherent risks involved in riding and working around horses, including bodily injury from riding or being in close proximity to horses, among other risks, and further that both horse and rider can be injured in normal use, or in competition and schooling. In order to provide this valuable service, **NO LIABILITY** can be accepted by the **MOVE A CHILD HIGHER, INC.** (MACH 1) program or any of the organizations or persons connected with the above-named facility.

IN CONSIDERATION for the privilege of riding and/or working around horses at the **MOVE A CHILD HIGHER, INC.** (MACH 1) program, the undersigned, as self or as parent or guardian of a minor participating in the program, jointly and severally do hereby agree to release, hold harmless and indemnify the **MOVE A CHILD HIGHER, INC.** (MACH 1) program, its officers, directors, trustees, agents, employees, representatives, successors and assigns, from all manner of liability, loss, costs, claims, demands and damages of every kind and nature whatsoever, including, but not limited to reasonable attorneys' fees, which the undersigned or said minor may now or in the future have against the **MOVE A CHILD HIGHER, INC.** (MACH 1) program, its officers, directors, trustees, agents, employees, representatives, successors and assigns, on account any accident, damage, injury or illness, physical or mental condition, known or unknown, to the undersigned or said minor, or the treatment thereof, arising as a result of, or in any way connected to acts or incidents occurring at or relating to the **MOVE A CHILD HIGHER, INC.** (MACH 1) program, its officers, directors, trustees, agents, employees, representatives, successors and assigns, including but not limited to their negligence or gross negligence in rendering services described above or in any way incidental thereto.

The undersigned, as self or as parent or guardian of a minor participating in the program, jointly and severally do hereby agree to release, hold harmless and indemnify the **CITY OF PASADENA** and its employees, agents and representatives.

The undersigned further agrees to use only those facilities of the Rose Bowl Riders Property set aside for use by **MOVE A CHILD HIGHER, INC.** (MACH 1), and to stay away from the Rose Bowl Riders horses and other property, unless accompanied by an authorized **MOVE A CHILD HIGHER, INC.** (MACH 1) personnel.

PARTICIPANT NAME (PLEASE PRINT): _____

PARENT/ GUARDIAN NAME (PLEASE PRINT): _____ RELATIONSHIP TO PARTICIPANT: _____

SIGNATURE: PARENT OR LEGAL GUARDIAN: _____ DATE: _____

SIGNER'S ADDRESS (CITY-STATE-ZIP CODE): _____



RELEASE AND HOLD HARMLESS AGREEMENT FOR ROSE BOWL RIDERS

MOVE A CHILD HIGHER, INC. (MACH 1) provides therapeutic horseback riding for disabled children. Horseback riding is a risk exercise, so volunteers and horses are carefully selected and trained and safety equipment is required for all riders.

No student will be accepted for riding instruction and no participants accepted for service until this form has been **READ, UNDERSTOOD, COMPLETED AND SIGNED** by the parent(s) or guardian(s) of a minor or by the student or volunteer if of legal age and sound mind.

Although participation in the **MOVE A CHILD HIGHER, INC.** (MACH 1), program is under strict supervision and every effort is made to avoid injury or accident, the undersigned acknowledges the inherent risks involved in riding and working around horses, including bodily injury from riding or being in close proximity to horses, among other risks, and further that both horse and rider can be injured in normal use, or in competition and schooling. In order to provide this valuable service, **NO LIABILITY** can be accepted by the **MOVE A CHILD HIGHER, INC.** (MACH 1) program or any of the organizations or persons connected with it or **ROSE BOWL RIDERS**.

IN CONSIDERATION for the privilege of riding and/or working around horses at the **MOVE A CHILD HIGHER, INC.** (MACH 1) program, the undersigned, as self or as parent or guardian of a minor participating in the program, jointly and severally do hereby agree to release, hold harmless and indemnify the **MOVE A CHILD HIGHER, INC.** (MACH 1) program and **ROSE BOWL RIDERS**, its officers, directors, trustees, agents, employees, representatives, successors and assigns, from all manner of liability, loss, costs, claims, demands and damages of every kind and nature whatsoever, including, but not limited to reasonable attorneys' fees, which the undersigned or said minor may now or in the future have against the **MOVE A CHILD HIGHER, INC.** (MACH 1) program, its officers, directors, trustees, agents, employees, representatives, successors and assigns, and **ROSE BOWL RIDERS**, its officers and directors, trustees, agents, employees, representatives, successors and assigns on account of any accident, damage, injury or illness, physical or mental condition, known or unknown, to the undersigned or said minor, or the treatment thereof, arising as a result of, or in any way connected to acts or incidents occurring at or relating to the **MOVE A CHILD HIGHER, INC.** (MACH 1) program, its officers, directors, trustees, agents, employees, representatives, successors and assigns, and **ROSE BOWL RIDERS**, its officers and directors, trustees, agents, employees, representatives, successors and assigns including but not limited to their negligence or gross negligence in rendering services described above or in any way incidental thereto.

The undersigned further agrees to use only those facilities of Rose Bowl Riders set aside for use by **MOVE A CHILD HIGHER, INC.** (MACH 1), and to stay away from the Rose Bowl Riders clubhouse, offices, bathrooms, barns and other property, including horses, unless accompanied by an authorized **MOVE A CHILD HIGHER, INC.** (MACH 1) personnel.

PARTICIPANT NAME (PLEASE PRINT): _____

PARENT/ GUARDIAN NAME (PLEASE PRINT): _____ RELATIONSHIP TO PARTICIPANT: _____

SIGNATURE: PARENT OR LEGAL GUARDIAN: _____ DATE: _____

SIGNER'S ADDRESS (CITY-STATE-ZIP CODE): _____



Confidentiality Agreement, Photo and Video Release

Confidentiality Agreement:

I understand that all the information (written and verbal) about participants at this NARHA center is confidential and not to be shared with anyone without expressed written consent of the participant and their parent/guardian in the case of a minor.

Date: _____

Signature: _____
(Participant, Parent or Caregiver)

Photo and Video Release:

_____ I consent to and authorize

_____ I do not consent to nor do I authorize

The use and reproduction by Move A Child Higher of any other audio/visual materials taken of me/my son/my daughter/my ward for distribution to the public for promotional printed materials, educational activities or for any other use for the benefit of the program.

Date: _____

Signature: _____
(Participant, Parent or Caregiver)



Authorization for Emergency Medical Treatment Form

Participant Staff Volunteer

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to Medications: _____

Current Medications: _____

In the Event of an Emergency Contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Please fill in either the consent or non-consent and sign and date underneath your choice.

Consent for Emergency Medical Treatment

In the event of an 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 _____ to:
(Center's Name)

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

This authorization includes x-rays surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: _____ Consent Signature: _____
Client, Parent or Legal Guardian

Non-Consent for Emergency Medical Treatment

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.

Parent or legal guardian will remain on site at all times during equine assisted activity

In the event emergency treatment/aid is required, I wish the following procedure to take place:

Date: _____ Non-Consent Signature: _____
Client, Parent or Legal Guardian
Signed in Presence of center staff



MACH 1

Annual Health History

Contact Information Update Form

Date: _____

Name of Participant: _____

Name of Parents/Guardian (if applicable): _____

Address: _____

City: _____ Zip: _____

Home Phone: _____ Cell: _____

E-mail: (please print clearly) _____

Participant DOB: _____ Sex: _____ Height: _____ Weight: _____

Diagnosis changes: _____

Emergency Contact Name: _____

Phone: _____ Relationship: _____

Preferred Medical Facility: _____

Physicians Name: _____

Health Insurance Company: _____ Policy#: _____

Current Medications: _____

Allergies: _____

Precautions/Restrictions: _____

Please explain any recent changes in health or behavior status: _____

Signature: _____ Date: _____

Print Name and Relationship: _____



Move A Child Higher

Possible Reasons for Client/Visitor Discharge

Please be advised of the following reasons that may lead to discharge from the riding program.

1. The client has reached all of their goals and is ready to graduate.
2. The client's potential to maintain head and neck control while riding presents a safety concern.
3. Inability to follow directions is interfering with progress toward goals.
4. Uncontrolled and/or inappropriate behavior that constitutes a safety risk to client, staff and/or horse.
5. Client exceeds weight that can safely be managed by staff, volunteers, and/or horses.
6. Any change in the client's medical, physical, cognitive, or emotional condition that makes therapeutic riding inappropriate and riding may become contraindicated.
7. Three scheduled appointments are missed without prior excused absence (see page 3).
8. Non-payment of fees as originally agreed.
9. Lack of motivation. The student should show enthusiasm for the program and actively participate in lessons and not resist staff, volunteers or horse.
10. Improper conduct from the student or visitors

I understand and agree with the possible reasons for client discharge.

Signature of Client or Legal Guardian: _____

Date: _____



MACH 1 Rider Goals

Please help us help you get the most out of your classes by filling out the following goal setting sheet. Please hand back to your instructor at the next class.

Thank you.

Rider name: _____

Parent name: _____

Email address: _____

Class day/time: _____

All goals are reflective of the next term. The categories are meant as a guideline and may not apply to all students.

Personal riding goals: _____

Physical goals: _____

Cognitive goals: _____

Social goals: _____

Long-term goal over the next year.

Goals Dated: _____



Dear physician,

One of your patients is interested in therapeutic horseback riding lessons. Each new student must submit a completed Physician's Assessment Form in order to enroll in our program. Your time completing this form will help our therapists and instructors in designing a safe, effective individual lesson plan for your patient.

Therapeutic riding is an effective way to improve the quality of life for many children with disabilities, physical, cognitive and psychological. Move A Child Higher is a PATH (Professional Association of Therapeutic Horsemanship International) Premier Center. Your participation in our program is welcomed and invited.

Sincerely,

Cric Dupuis, Director of Operations
626-695-2894



Information for Physician

Date: _____

Dear Physician,

Your patient, _____ (participants name) is interested in participating in supervised equestrian activities.

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

Orthopedic

Spinal Fusion/Fixation
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathological Fractures
Coxas Arthrosis
Heterotopic Ossification
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Neurologic

Hydrocephalus/shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis due to Spinal Cord Injury
Seizure Disorders

Medical/Surgical

Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident)

Secondary Concerns

Behavior Problems
Age under Two Years
Age Two - Four Years
Indwelling Catheter
Acute Exacerbation of
Chronic Disorder



**(Please give to the rider's physician as a guideline for Therapeutic Riding)
Rider Health History/ Physician Assessment**

Rider Name: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizures Y N Type: _____ Controlled Y N Date of Last Seizure: _____

Shunts/Implants/Appliances: _____

Hospitalizations/Surgery: _____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Neurologic Symptoms of Atlanto Axial Instability: _____

Please indicate and comment on any Special Problem Areas Below:

Area	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological/Sensation			
Bowel/Bladder			
Muscular			
Orthopedic			
Allergies			
Behavior			
Cognition			
Emotional/Psychological			
Other			



Down Syndrome Students must have the following:
Atlantoaxial Interval X-ray: Date: _____ Result: _____

Parent/rider signature: _____ Date: _____

Physician Release

Rider Name: _____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However I understand that MACH 1 will weigh the medical information contained in the physician release form against 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, Therapist, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician's Signature: _____

Date: _____

Physician's name, address and telephone number (please print, type or stamp):

(To be filled out, dated and signed by the Riders Physician and returned to MACH 1 prior to any participation in the program)