



4:13 Therapeutic Riding Registration Package

Four: Thirteen Therapeutic Riding Association (4:13) welcomes students with all abilities from the age of 5 and up. We operate our therapeutic riding programs out of High Country Equestrian Center.

Who benefits from therapeutic riding?

All Abilities: Attention Deficit Hyperactive Disorder, Anxiety, Auditory & Visual Impairment, Autism Spectrum Disorders, Brain Injury, Cerebral Palsy, Cognitive Disabilities, Developmental Delay, Down Syndrome, Fine and Gross Motor Skill Delays, Language & Learning Disabilities, Multiple Sclerosis, Neurological, Psychological, Physical, and/or Mental Disorder, Spinal Cord Injury and many more .

How does Therapeutic Riding benefit a person?

Physical Benefits: Warmth and three dimensional movement of the horse is transmitted through the rider's body, gradually making any tension more relaxed this reduces spasms, improving balance, mobility, posture and co-ordination, also, strengthens muscles throughout a rider's body, increases circulation and promotes better overall health. Muscle tone, balance, coordination, muscle strength, flexibility, fitness, posture, gait (ability to walk), respiration, circulation, metabolism, sensory perception and integration, independence: self-care and mobility. Therapeutic riding gently and rhythmically moves the rider's body in a manner similar to a human gait so those with mobility problems discover a new freedom in movement. Motor function is improved by this unique and enjoyable therapy.

Psychological Benefits: Concentration, problem solving and decision making, insight, motivation, self- esteem, confidence, learning/practicing concepts e.g. letters, numbers, colors, distances, shapes etc. **Social Benefits:** Communication and social skills, recognize positive behavior, develops awareness, responsibility, and helps builds relationships. The unique relationship formed with their horse can lead to increased confidence, patience, self-esteem and improves emotional well-being, along with a sense of independence.

Therapeutic riding benefits participant of all abilities physically, cognitively and socially in an experience they will not soon forget.

4:13 Instructor: We are proud to retain the services of CANTRA certified and experienced therapeutic riding instructor Sue Clark. Along with certified Equine Assisted Learning coach Teray Wills.

Location: 240020 RR 42, Calgary, AB, located on the south east corner of Hwy # 8 and Hwy # 22 just west of Calgary. **To get to the barn** go south from the highway 8/22 traffic circle. Take the first left on Circle 5 Est. After about 1km make a sharp right on to RR 42 (turn before large stone gate) head up the hill and the center is at the top on the left.

Program Cost:

\$400 per rider for 8 Week session

\$300 per rider for 6 Week session

Visit our website for session days and times: 413therapeuticriding.com/program-registration

***Session will not be confirmed until registration and payment is received**

- ! All riders must wear a boot or shoe with a heel and **horse** riding helmets are mandatory. These may be purchased at various horse equipment stores in Calgary. We also have helmets here that can be used, although there is a preference that you acquire your own helmet. "The Horse Store" is a sponsor and will give discounts to 4:13 participants.
- ! Please note that 4:13 Therapeutic Riding has a weight limit policy of **a maximum of 175 lbs** in order to ensure the safety of both our horses and volunteers

Participant Application and Medical History Form

Rider's Last Name: _____ Rider's First Name: _____

Parent/ Guardian: _____

Rider's address: _____

Parent/ Guardian Address (if different from above) _____

Phone: home _____ work _____

cell _____ e mail _____

Emergency Contact: Name: _____ phone: _____

Rider's date of birth: _____ Age: _____ Height: _____ Weight: _____

Rider's Alberta Health Care Number _____

Health Insurance Company: _____ Policy # _____

Physicians Name: _____ Tel: _____

Physicians Address: _____

Preferred Medical Facility: _____

Have you discussed, and gained approval and consent from your physician regarding specific participation in horseback riding activities ? Yes _____ No _____

*****Note: You must have participants' physician fill out and initial the Professional Medical Statement below.

Diagnosis: _____ Past/Prospective

Surgeries _____

Allergies (medical and environmental): _____

Current Medications
(include both prescriptive and non- prescriptive herbs and supplements with name, dose and frequency):

Impairments in Dexterity, Flexibility, Movement (mobility skills such as transfers, walking, wheelchair use, driving/bus riding):

Psycho/Social Function (Work/School grade completed, leisure interests, relationship family structure, support systems, companion animals, fears/concerns):

Assistance required/Assistance Equipment required (include all assistance required or equipment needed):

Goals (why are you applying for participation ? what would you like to accomplish ?): _____

Past or Current Special Needs

	Yes	No	Comments
Vision/Visual			
Hearing/Auditory			
Sensation/Tactile Sensation			
Heart/Cardiac			
Breathing/Pulmonary			
Digestion/Gastrointestinal			
Elimination/Incontinence			
Circulatory			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognitive Function			
Allergies			
Immunity			
Neurological			
Balance			
Orthopedic			
Learning Disability			

Independent Ambulation Assisted Ambulation			
Wheelchair			
Braces/ Assistive Devices			
Downs Syndrome: AtlantoDens Interval x-ray date and results (+ or -)			
Other			

Participant Signature : _____ Date: _____

Guardian Signature : _____ Date: _____

<p style="text-align: center;">Professional Medical Statement</p> <p style="text-align: center;">** to be filled out by Supervising Medical Professional **</p> <p>To my knowledge there is no reason why this person cannot participate in supervised equine activities and horseback riding. I understand that Four: Thirteen Therapeutic Riding Association weighs the medical information provided above, against the existing precautions and contraindications prior to any participants acceptance into a riding program.</p> <p>I concur with this person's abilities to participate (please initial): _____ Participate in Horseback Riding.</p> <p>Please note any additional information that is incomplete or not mentioned</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Full Name: _____ Professional Title (eg MD/PT/OT): _</p> <p>Signature: _____ Date: _ Address: _____</p> <p>Tel: (____) _____ - _____ Email: _____</p>

Conditions of Registration:

1. Payment in full must be made at time of registration via:
 - a. Cheque made payable to "Four: Thirteen Therapeutic Riding Association"
 - b. Etransfer to info@413therapeuticriding.com – Auto Deposit. *Please Note Participant Name and Session in Memo*
2. Cancellation Policy: Fees are 100% non-refundable and non-transferable*.
3. Due to the nature of the riding program please include a doctor's note with your registration documents stating that it is safe for student to participate in horse backing riding activities.
4. Four: Thirteen Therapeutic Riding Association (4:13) and High Country Equestrian Center (HCEC) and individuals that represent them reserve the right to arrange for any special service, obtain and approve any medical attention deemed necessary in the best interest of the participants. Hereby guardian agrees to pay in full all costs of such event.
5. The participant/Guardian agrees to thoroughly read, understand and sign a "Waiver of Release" of 4:13/ High Country Equestrian Center prior to participating in this horse activity.
6. *All students will undergo an assessment to evaluate their suitability for this program. If for any reason the instructor finds the student unable to participate, a full refund will be given.

Participant/ Guardian Signature: _____ Date: _____

In order to make this a fun and positive experience for each participant, please add any information on their likes/dislikes or any information you believe would be helpful.

Please send completed form and payment to:

Email: info@413therapeuticriding.com

or

Mail:

Four: Thirteen Therapeutic Riding Association
High Country Equestrian Center
41194 Circle 5 Est Calgary, AB,
T3Z 2T5



PHOTO RELEASE FORM



I, the undersigned (Please circle) DO
DO NOT

Consent and authorize the use and reproduction by “Four: Thirteen Therapeutic Riding Association” and “High Country Equestrian Center” of any and all photographs and any other audio/visual materials taken of me for promotion material, educational activities, exhibition or for any other use for the benefit of the program.

(18 years and older)

Name of Rider (print): _____

Signature: _____ Date: _____

(If under 18 or guardianship in place)

Name of Rider (print): _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (print): _____

FOUR: THIRTEEN THERAPEUTIC RIDING ASSOCIATION
Degree of Bodily Contact Policy

Policy:

Due to the nature of the work at Four: Thirteen Therapeutic Riding Association, it is understood that instructors and trained volunteers will need to physically assist the majority of riders in one or more of the following areas, and it is understood that this is part of the therapy/recreation session to which riders and parents have consented.

- When mounting, dismounting or riding a horse
- When lifting a rider onto the horse, to correct posture by placing hands at the front or back of the trunk, to correct leg and hand positions
- During riding sessions when having to quickly physically remove a rider from the group, due to behavioural or other concerns, and which is done for the well-being of all concerned (this may involve two staff members lifting a rider)

Any bodily contact provided by trained staff or personal care workers is in the interest of providing a safe and fun environment for the rider, and will be undertaken with the utmost discretion.

Many of the riders' with special needs who attend Four: Thirteen Therapeutic Riding Association like to give hugs. This will be monitored by staff so that other riders, centre personnel or volunteers will not be placed in an embarrassing situation and behaviour will be modified as deemed necessary.

I have read, understood and agree to the term of the policy

Name: _____

Date:

Signature: _____

Witness:

(Parent/Guardian if rider under 18 years of age)

Additional Release Form for Applicants with Seizures

Applicant has been seizure-free for six months while on medication or for one year without medication (Note: Riders with uncontrolled seizures are not permitted to ride)	Yes ____	No ____
Applicant has absence seizures (Note: Riders with absence seizures which do not affect the rider's balance, posture or tone will not be allowed to ride independently but may still be accepted to ride with MVSRA and are subject to MVSRA approval)	Yes ____	No ____
The applicant's Doctor has approved riding as suitable for the applicant	Yes ____	No ____

Please read & sign: I would like _____ to have riding instruction.

I am aware of the risk and potential for additional risks for riders with seizures. I have read the Canadian Therapeutic Riding Association (CanTRA) Policy regarding seizures. I understand that NO LIABILITY can be accepted by any organizations or individuals concerned with this riding instruction; including Four: Thirteen Therapeutic Riding Association and or any one providing facilities, equipment or support. I, hereby intending to be legally bound for myself, my heirs and assigns, executors and administrators, wave and release forever all claims of damage against Four: Thirteen Therapeutic Riding Association, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses the rider may sustain while participating in Four: Thirteen Therapeutic Riding.

Parent/Guardian Signature

Date

FOUR: THIRTEEN THERAPEUTIC RIDING ASSOCIATION

Child Participant Release of Liability Agreement

I, (parent/guardian) _____ for and in consideration of the agreement for Four: Thirteen Therapeutic Riding Association and High Country Equestrian Center (4:13 and HCEC) to provide Therapeutic Riding and Equine Assisted Activities to my child (name) _____, do hereby forever release, acquit, discharge and hold harmless 4:13 and HCEC, its officers, trustees, agents, employees, representatives, successors and assigns, for all manner of claims, demands, and damages of every kind and nature whatsoever; which the undersigned may now, or in the future, have against 4:13 and HCEC or, its officers, trustees, agents, employees, representatives, successors and assigns on account of any personal injuries including death, physical or mental condition, known or unknown, to the undersigned and the treatment therefore as a result of, or in any way growing out of, the acts of 4:13 and HCEC, its officers, trustees, agents, employees, representatives, successors and assigns, including but not limited to, their negligence or gross negligence, in rendering the services above described in any way incidental thereto.

Signature of Parent/Guardian: _____ Date: _____

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 farm, I authorize 4:13 to:

- Secure and retain medical treatment and transportation in needed,
- Attempt to contact parent and guardian, then the emergency contacts in the order listed below.
- Release client records upon request to the authorized individual or agency involved in the emergency medical treatment.

Parent Emergency Contact: _____ Tel: _____

Emergency Contact #1 _____ Tel: _____

Emergency Contact #2 _____ Tel: _____

Emergency Contact #3 _____ Tel: _____

Consent Plan

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

Consent Signature (Parent/Guardian): _____ Date: _____

Name (printed): _____

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:

Consent Signature (Parent/Guardian): _____ Date: _____

Name (printed): _____

<p align="center">ASSUMPTION OF RISKS, RELEASE OF INTEREST, WAIVER OF CLAIM, AND INDEMNITY AGREEMENT</p> <p align="center">BY SIGNING THIS DOCUMENT YOU WILL WAIVE CERTAIN LEGAL RIGHTS INCLUDING THE RIGHT TO SUE.</p> <p align="center">PLEASE READ CAREFULLY!</p>



Participant Name _____
Address _____
Phone No _____

Program/Purpose of visit: ☐ HCEC Riding lesson ☐ Therapeutic riding lesson ☐ Volunteer ☐ HCEC Employee ☐ Instructor
☐ Other: _____

To: **High Country Equestrian Center** (referred to in this agreement as the "Provider")

AND TO: ALL PROPERTY OWNERS (PRIVATE, FEDERAL, PROVINCIAL, REGIONAL AND MUNICIPAL)

On my behalf, and on the behalf of any minor children participating in these activities, for whom I am legally responsible, I agree to the following:

ASSUMPTION OF RISKS:

I am aware and understood that activities involving these horses involve many risks, dangers and hazards, including, but not limited to the following:

1. Horses, which are powerful and potentially dangerous animals, may change their behavior at any time and may, without warning, jump, run wildly, buck, kick, bite or step on people or things;
2. Horses may collide with other horses or objects or trip, stumble or fall even if being led, ridden, or attended to;
3. Negligence (which means, in general terms, a failure to exercise ordinary or proper care) of other riders or my or my child's own failure to ride safely within my or my child's ability or within designated areas and trails;
4. Equipment may fail;
5. Weather conditions can change and can sometimes be dangerous;
6. The nature of the terrain can change and has certain risks associated with it including, but not limited to, exposed natural objects, trees, streams and creeks;
7. The activities can sometimes be in remote areas and injuries or illness may occur and it may be a considerable distance to doctors, hospitals, or any other type of assistance; and
8. Negligence on the part of A PROPERTY OWNER AND/OR THE PROVIDER OR THEIR STAFF.

I am also aware that the risks, dangers and hazards referred to above exist throughout the trail, stable, practice and other areas and many are unmarked. I understand and acknowledge that no amount of caution, experience and instruction can eliminate all of the risks involved and I freely accept and fully assume all such risks, dangers and hazards and the possibility of personal injury, death, property damage and damages or loss resulting there from.

Initials	HCEC Initials
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RELEASE OF LIABILITY, WAIVER OF CLAIMS AND INDEMNITY AGREEMENT

In consideration of the Provider providing me or my child with their horses and other services and permitting my or my child's use of their equipment, and other facilities and the Property Owners providing me or my child with the use of their property (hereinafter collectively) referred to as "the Services"), I hereby agree as follows:

1. TO WAIVE ANY AND ALL CLAIMS that I or my child have or may in the future have against a Property Owner or the Provider, and their directors, officers, employees, agents, representatives, and volunteers (all of whom are hereinafter collectively referred to as "THE RELEASEES") and TO RELEASE THE RELEASEES from any and all liability for any loss, damage, injury or expense that I or my child may suffer, or that my or my child's next of kin may suffer as a result of my or my child's use of the services or due to any cause whatsoever, INCLUDING NEGLIGENCE, BREACH OF CONTRACT, OR BREACH OF ANY STATUTORY OR OTHER DUTY OR CARE INCLUDING ANY DUTY OF CARE OWED UNDER THE "OCCUPIERS LIABILITY ACT" ON THE PART OF THE RELEASEES;
2. TO HOLD HARMLESS AND INDEMNIFY THE RELEASEES from any and all liability for any damages to the property of or personal injury to any third party resulting from my or my child's use of the services;
3. This Agreement shall be effective and binding upon my or my child's heirs, next of kin, executors, administrators, assigns and representatives in the event of my or my child's death or incapacity;
4. This agreement shall be governed by and interpreted in accordance with the laws of the Province of Alberta ; and
5. Any litigation involving the parties to this Agreement shall be brought within the Province of Alberta.

Initials	HCEC Initials
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PROTECTIVE HEAD GEAR & RIDING BOOTS

1. Proper riding footwear is required by all persons, regardless of age, participating in any horse related activities.
2. ALL MINORS (Horseback riders under 18 years of age) are required to wear protective head gear in the form of a high impact helmet and proper footwear.
3. IT IS HIGHLY RECOMMENDED THAT ALL HORSE BACK RIDERS OF ANY AGE WEAR A HIGH IMPACT HELMET.
4. I (we) decline to wear a helmet(s).

Initials	HCEC Initials
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In entering into this Agreement, I am not relying upon any oral or written representations or statements made by the Releasees other than what is set forth in this Agreement. I HAVE READ AND UNDERSTOOD THIS AGREEMENT AND I AM AWARE THAT BY SIGNING THIS AGREEMENT, FROM THIS DAY FORWARD, I AM WAIVING CERTAIN LEGAL RIGHTS WHICH I, MY CHILD, MY HEIRS, NEXT OF KIN, EXECUTORS, ADMINISTRATORS, ASSIGNS AND/OR REPRESENTATIVES MAY HAVE AGAINST THE RELEASEES.

<p>Name _____</p> <p>Address _____</p> <p>Phone No _____</p> <p>Signature _____</p> <p>Date of Signature _____</p> <p>(A parent or guardian must sign for children under 18 and/ or legally incapable persons)</p>	<p>Witness _____</p> <p>Address _____</p> <p>Phone No _____</p> <p>Signature _____</p> <p>Date of Signature _____</p>
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THIS AGREEMENT MUST BE COMPLETED IN FULL, SIGNED, DATED, AND WITNESSED BEFORE ANY ACTIVITY WITH HORSES MAY BE UNDERTAKEN.