



DREAM A DREAM THERAPEUTIC HORSEMANSHIP  
23650 Round Mountain Circle ♦ Leander, TX 78641  
(512) 260-5957 ♦ info@dadth.org

Dear Prospective Client:

We welcome your interest in our program. D.A.D.T.H. is one of approximately 750 riding centers which are members of the Professional Association of Therapeutic Horsemanship International or PATH International. Our goal is to partner with our equine friends to provide love, hope and therapy for children and adults with physical, mental and emotional disabilities.

In order to provide the best therapeutic benefit and the safest environment to our clients, D.A.D.T.H. has established some minimal guidelines for acceptance into the D.A.D.T.H. program. First, it is preferred that clients be at least 3 years of age. D.A.D.T.H. will accept clients as young as 30 months if the client exhibits head control and emerging trunk control. Secondly, clients who ride independently must weigh no more than 200 lbs., and a client who requires a back rider must weigh no more than 75 lbs.

If the client meets these criteria, here is how to register. First, complete the enclosed forms. Be sure that all forms are dated with the same date as the date your doctor signs the Client Medical History and Physician Statement form. The Client's Medical History must be completed, signed and dated by the client/parent or guardian. The client's Physician will need to complete, sign and date the Physician's Statement portion. It often takes a little time to get this done, so we recommend that you pursue this as soon as possible. All forms must be completed and returned before you or your child can be enrolled. Once you are in our program, all forms are required to be renewed annually based on the date of the physician's signature on the Client Medical History and Physician Statement form.

Please mail the completed forms along with a **\$25 fee** payable to Dream A Dream Therapeutic Horsemanship. The \$25 fee includes a registration fee and covers the cost the instructor's evaluation. Upon receipt of the completed forms and the \$25, you will be contacted to set up an appointment for your evaluation. Potential clients Do Not ride a horse at the initial evaluation. Please review the attached list of contraindications. If the client has one or more of these conditions, therapeutic riding is not recommended. The instructor will not approve the client's enrollment and the \$25 fee is not refundable. Please call if you have any questions concerning these contraindications.

Finally, upon completion of the evaluation, a ride time will be discussed and the client will be in the program.

In this packet, you will find not only the Physician's statement, but also a rider application and health history, program overview, goals and barn rules. Please retain copies for your future reference and mail the completed copies to the address above.

We look forward to working with you and your rider and to the wonderful world of horses.



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## **PROGRAM OVERVIEW**

D.A.D.T.H. is staffed with a PATH International certified instructor who evaluates the needs and abilities of each client. With this information, a lesson plan will be developed that is specifically designed to benefit the client. The horse leaders and sidewalkers volunteer their time to insure the safety of the clients.

## **PROGRAM GOALS**

**THERAPEUTIC RIDING** – Based on individual needs, the goals of the program are for the client to improve his or her:

- ♦ Muscle Tone
- ♦ Range of Motion
- ♦ Rhythm
- ♦ Attention Span
- ♦ Spatial Organization
- ♦ Judgment
- ♦ Muscle Strength
- ♦ Balance
- ♦ Coordination
- ♦ Sensory Awareness
- ♦ Sequential Performance
- ♦ Reasoning

**HORSEMANSHIP SKILLS** – Based on individual needs and site limitation, clients may develop the following skills:

- ♦ Reining
- ♦ Cantering
- ♦ Vaulting
- ♦ Stable management
- ♦ Posting to trot
- ♦ Horse handling/ground skills

**ALL STUDENTS** – For every client, the goals of the program include:

- ♦ Enhancing functional skills
- ♦ Developing Self Esteem

**COMPETITION** – Based on individual goals, the program offers the opportunity to participate in one of the following:

- ♦ D.A.D.T.H. Fun Day
- ♦ Top Hands Horse Show
- ♦ Special Olympics



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## **D.A.D.T.H. Rider RULES AND REGULATIONS**

While providing our students, volunteers, staff and families with services, safety is a top priority. These rules and regulations are stated to help insure safety and we ask your assistance in making sure that everyone follows them.

1. A parent or designated adult must be on the premises at all times during the time a student is on D.A.D.T.H. property participating in class.
2. Students/Guardians/Parents will be required to sign a variety of forms, including but not limited to a photo release, liability release, emergency medical form and attending physician forms. Forms must be signed prior to any participation in D.A.D.T.H. activities.
3. As of September, 1995, Texas enacted the following Law:  
Texas Law (Chapter 87, Civil Practice and Remedies Code), an equine professional is not liable for the injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities.
4. Only staff, volunteers and students will be allowed beyond designated visitor areas. Off limit areas include, but are not limited to, the horse tacking area, mounting ramp, horses stalls, tack room and arena. For the safety of everyone, this rule will be strictly enforced.
5. Permission must be obtained from the student, parent, instructor and volunteers before photos are taken or videos taped.
6. Unsupervised children are not allowed at D.A.D.T.H. Siblings of students must be supervised at all times while on D.A.D.T.H. premises. Siblings will NOT be allowed in "authorized personnel only" areas including stalls unless supervised by an instructor.
7. Personal pets are not allowed on the property unless prior arrangements have been made with the instructor.
8. Students should be punctual for classes. This will allow everyone the opportunity to ride for his/her allotted time.
9. Students should dress appropriately for horse related activities. This includes but is not limited to long pants, closed toe shoes or boots, with heels, ASTM/SEI approved riding helmet (can be provided by program), and weather appropriate attire.
10. Never hand feed treat to horses.
11. Developmental or riding skills classes are \$55 for a private session, \$45 for a group session, \$25 for a 1/2 hour session, and \$75 for a hippotherapy session. All classes are payable in advance and due the 1st of each month. Please make checks payable to "Dream A Dream Therapeutic Horsemanship".



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12. Lesson cancellation due to bad weather – please call to determine cancellation. If the cancelled lesson is not rescheduled, you may either request a credit for the next month or you may regard it as a donation to D.A.D.T.H.
13. It is mandatory that everyone comply with all posted safety rules. Smoking or the use of drugs or alcohol on the property is strictly forbidden. No mistreatment, abuse, or verbal suggestions of abuse of any animal or person will be tolerated.

**We reserve the right to ask anyone to leave the premises.**

**Our primary goal is for everyone at D.A.D.T.H. to have a fun, successful and safe experience. Please help us achieve this goal.**

I have read and understand what is written and agree to follow the rules and regulations set forth by Dream A Dream Therapeutic Horsemanship, D.A.D.T.H. I understand and am aware of the Texas Equine Liability Act.

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Signature of \*rider, parent or guardian

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Date

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Printed name of \*rider, parent or guardian

**\*If the student is under the age of eighteen (18), a parent or guardian must sign and date for the minor.**



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APPLICATION and HEALTH HISTORY for EQUESTRIAN

GENERAL INFORMATION

Participant: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: M F

Street Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Alternative Phone No.: ( ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

School or facility presently attending/living: \_\_\_\_\_

Parent/Legal Guardian/Caregivers: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Telephone Number if different from above: \_\_\_\_\_

Referral Source/How did you hear about D.A.D.T.H. \_\_\_\_\_

LIABILITY RELEASE

(Rider's Name) would like to participate in the D.A.D.T.H. riding program. I acknowledge the risks and potential for risks for horseback riding. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally found, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against D.A.D.T.H., its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses/l/my son/my daughter/my ward may sustain while participating in the D.A.D.T.H. program

Under Texas Law (Chapter 87, Civil Practice and Remedies Code), an equine professional is not liable for any injury to or the death of a participant in equine activities resulting from the inherent risk of equine activities.

I consent: \_\_\_\_\_ Date: \_\_\_\_\_
Signature of person with legal authorization: client, parent or guardian

Non-consent: \_\_\_\_\_ Date: \_\_\_\_\_
Signature of person with legal authorization: client, parent or guardian



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**PHOTO RELEASE**

I  DO  DO NOT consent to and authorize the use and reproduction by D.A.D.T.H. of any and all photographs and any other audio/visual materials taken of the rider for promotional materials, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Person who has legal authorization: Client, Parent or Legal Guardian

**HEALTH HISTORY**

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Please indicate current or past special needs in the following areas:

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			
Seizures			

**MEDICATIONS** (Include prescription, over-the-counter; name, dose and frequency):

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Describe the rider's abilities/difficulties in the following areas (include assistance required or equipment needed):

**PHYSICAL FUNCTION** (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding):

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**PSYCHO/SOCIAL FUNCTION** (i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns etc.):

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**GOALS** (i.e. Why are you applying for participation? What would you like to accomplish?)

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Do you have any conditions, which might be affected by the weather (heat, cold), the environment (insect allergies, asthma, dirt), or the animals (allergies)?

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AUTHORIZATION for EMERGENCY MEDICAL TREATMENT FORM

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Address: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Current medications: \_\_\_\_\_

In the event of an emergency, contact: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

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CONSENT PLAN

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 property of D.A.D.T.H., I authorize D.A.D.T.H. to:

- 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-ray, surgery, hospitalization, education 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: \_\_\_\_\_
Signature of legally authorized person, client, parent or guardian

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.

- 1. Parent or legal guardian will remain on site at all times during equine assisted activities.
2. In the event emergency treatment/aid is required, I wish the following procedure to take place:

\_\_\_\_\_
\_\_\_\_\_

Date: \_\_\_\_\_ Non-Consent Signature: \_\_\_\_\_
Signature of legally authorized person, client, parent or guardian



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PARTICIPANT'S CONSENT for RELEASE of INFORMATION

This page is to be used when you are authorizing a person or facility to release information to D.A.D.T.H. or if you are authorizing D.A.D.T.H. release information to another person or facility.

I hereby authorize: (person or facility)

To release information from the records of: (participant's name) DOB:

The information is to be released to: (center or therapist's name)

for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

- Medical History
Physical Therapy evaluation, assessment and program plan
Occupational Therapy evaluation, assessment and program plan
Speech Therapy evaluation, assessment and program plan
Mental Health diagnosis and treatment plan
Individual Habilitation Plan (I.H.P.)
Classroom Individual Education Plan (I.E.P.)
Psychosocial evaluation, assessment and program plan
Cognitive-Behavioral Management Plan
Other:

This release is valid for one year and can be revoked, in writing, at my request.

Signature: Date:

Print name: Date:

Relation to Participant:

Please send materials to:

Blank lines for address information

(First of two pages to be completed by Health Care Provider)



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Dear Health Care Provider:

One of your patients is interested in participating in supervised equine activities. In order to safely provide this service, D.A.D.T.H. requests that you complete/update the attached Medical History and Physician’s Statement. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present and to what degree.

Orthopedic:

Atlantoaxial Instability - include neurological symptoms

Medical/Psychological:

- |                                                                  |                                 |
|------------------------------------------------------------------|---------------------------------|
| Coxa Arthrosis                                                   | Allergies                       |
| Cranial Deficits                                                 | Animal Abuse                    |
| Heterotrophic Ossification/Myositis Ossificans                   | Cardiac Condition               |
| Joint Subluxation/dislocation                                    | Physical/Sexual/Emotional Abuse |
| Osteoporosis                                                     | Blood Pressure Control          |
| Pathologic Fractures                                             | Dangerous to self or others     |
| Spinal Joint Fusion/Fixation                                     | Exacerbations of medical        |
| Spinal Joint Instability/Abnormalities conditions (i.e., RA, MS) | Fire Settings                   |

Neurological:

- |                                                               |                     |
|---------------------------------------------------------------|---------------------|
| Hydrocephalus/Shunt                                           | Hemophilia          |
| Seizure                                                       | Medical Instability |
| Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia | Migraines           |
|                                                               | PVD                 |

Other:

- |                                        |                          |
|----------------------------------------|--------------------------|
| Indwelling Catheters/Medical Equipment | Respiratory Compromise   |
| Medications – i.e., photosensitivity   | Recent Surgeries         |
| Poor Endurance                         | Thought Control Disorder |
| Skin Breakdown                         | Weight Control Disorder  |

Thank you very much for your assistance. If you have any questions or concerns regarding this patient’s participation in equine assisted activities, please feel free to contact D.A.D.T.H.

**Rider’s Medical History & Physician’s Statement**

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Date of onset: \_\_\_\_\_ Past/Prospective Surgeries: \_\_\_\_\_

\_\_\_\_\_ Medications: \_\_\_\_\_

Seizure Type: \_\_\_\_\_ Controlled: Yes or No Date of Last Seizure: \_\_\_\_\_

**(Second of two pages to be provided to your health care provider.)**



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Special Precautions/Needs (Riders always wear certified helmets and safety stirrups are the only type used.): \_\_\_\_\_

Mobility: Independent Ambulation: Yes or No Assisted Ambulation: Yes or No

Wheelchair: Yes or No Braces/Assistive Devices: \_\_\_\_\_

For those with Down Syndrome: AtlantoDens Interval X-rays, date: \_\_\_\_\_

Result + - Neurological Symptoms or AtlantoAxial Instability: \_\_\_\_\_

*Please indicate current or past special needs in the following system/areas, including surgeries:*

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

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that D.A.D.T.H. will weigh the medical information given against the existing precautions and contraindications of the North American Riding for the Handicapped Association. Therefore, I refer this person to D.A.D.T.H. for ongoing evaluation to determine eligibility for participation.

Name/Title: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_