



WHAT IS SPIRIT THERAPIES?

Spirit Therapies is a place where riders with Down's Syndrome, Angelman's Syndrome, MS, Autism, Muscular Dystrophy, spinal cord injuries, emotional distress, and other disabilities experience the expansion of their worlds through the magic of connecting with horses.

Our horse are really four legged therapists, who help our riders improve their lives through physical contact, exercise, and interaction with others which increases communication and social skills.

As our rider's skills increase, so does their self-esteem and general well being. Research has proven that exercise and interpersonal interaction produces profound benefits for individuals with special needs working to reach their full physical, mental and social potential.

Spirit Therapies is dedicated to helping our riders discover their dreams and goals—to help them expand their physical and mental horizons, so they can free their true Spirit and be the best that they can be !

Spirit Therapies is a 501 (c) 3 non-profit organization. Someday through support of our friends, riders, volunteers, sponsors and the public, we will be able to offer our services free of charge through our Pegasus Program.

For more information, please visit our website at www.SpiritTherapies.org or call Laurie Willmott, Executive Director (702) 219-1728.



RIDER CRITERIA TO PARTICIPATE IN SPIRIT THERAPIES PROGRAM

The following criteria will be considered by Spirit Therapies professional staff prior to a rider being accepted into the program:

1. Riders may participate in Spirit Therapies only if their medical, physical and/or psychosocial conditions are within the Precautions and Contraindications Guidelines as defined by the NAHRA Medical Committee.
2. Riders must be three (3) years of age or older.
3. Riders are accepted into Spirit Therapies program only if there is an adequate number of staff and volunteers to safely serve them.
4. Riders must have all required forms completed, along with registration fees and first month's tuition paid prior to participating in Spirit Therapies program.
5. Riders who weigh over 170 pounds will be assessed for safe participation in the riding program.
6. Riders may be served by Spirit Therapies if there are horses suitable for them to ride.
7. Professional staff will assess a rider's attitude and behavior to ensure that there are no safety risks to the rider, staff, horses.
8. Riders will be admitted into the Spirit Therapies program based on time and space availability.
9. Riders may be included in Spirit Therapies program provided there is adequate facilities and equipment to safely meet their needs.
10. Riders may remain a participant in Spirit Therapies until such time when he or she no longer meets program criteria.
11. Riders will wear ASTM approved helmets.
12. To promote safety while their feet are in the stirrups, riders will wear riding boots or shoes with heels. If a rider does not have boots or hard soled shoes, then peacock stirrups will be used in the lesson.

I have read the above criteria and agree to follow its guidelines and requirements.

_____ Date: _____
Printed Name of Adult Rider, Parent, Guardian, or Caregiver

Signature of Adult Rider, Parent, Guardian, or Caregiver

RIDER REGISTRATION INFORMATION

Name of Rider: _____

Diagnosis/Disabling Condition: _____

Parent/Guardian (if rider is underage): _____
Print Name

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ 2nd Phone: _____

Parent/Guardian Work Phone: _____

E-mail address: _____

The annual rider registration fee is \$55.00 and includes:

- Insurance for the rider and parent/guardian for one year.
- All newsletters and other written materials.

Weekly rider fees are:

- \$45.00 per 1/2 hour private lesson per week with Therapeutic Riding Instructor
- \$35.00 per group lesson (1 hour lesson per week 2-4 riders) with Therapeutic Riding Instructor
- \$150.00 per hour with Mental Health Professional
- \$90.00 per hour with OT or PT

Partial Pay—Sponsorship

Riders who have any type of sponsorship including, but not limited to funding through Desert Regional Center, Equine Foundation, Air Warrior Courage, Down Syndrome Foundation, private scholarship, or Pegasus Program are personally responsible for paying a lesson fee of \$5.00 per rider per lesson. Your respective sponsor will be charged the difference. Money MUST be received in advance in order for the student to participate.

A rider may ride more than once per week. The fee will be the same amount, times the number of lessons per week. Fees may be paid by “Scholarship” money from family, friend, or organizations. The “Scholarship” is classified as a donation, and as such, is tax deductible for the donor.

If a rider needs financial assistance to participate in the program, please contact us at: (702) 219-1728 or (702) 562-9434.

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

Participant **Staff** **Volunteer**

Printed Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City/State: _____ Zip Code: _____

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: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, while being on the property of the center,

I authorize Spirit Therapies 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.

Consent Plan

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 are unable to be reached.

Printed Name: _____

Consent Signature: _____ Date: _____

Client, Parent or Legal Guardian
Signed in presence of center staff.

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.

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

Printed Name: _____

Signature: _____ Date: _____

Client, Parent or Legal Guardian
Signed in presence of center staff.

PARTICIPANT'S CONSENT FOR RELEASE OF INFORMATION

I hereby authorize Spirit Therapies to release information from the records of:

_____ DOB: _____
(Rider's name)

The information is to be released to Spirit Therapies for the purpose of developing an equine activity program for the above named rider. 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: _____

Relation to Participant: _____

Please send written information to:

INITIAL LETTER TO RIDER'S PHYSICIAN

(This is an initial letter to your rider's physician. Attach the Rider's Medical History & Physician's Statement)

Date: _____

Dear Health Care Provider: _____

Your patient, _____
(Rider's name)

is interested in participating in supervised equine 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 equine activities. Therefore, when completing this form, please note whether these conditions are present and to what degree.

Orthopedic

Atlantoaxial Instability - include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Instability/Abnormalities
Spinal Joint Fusion/Fixation

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/
Tethered Cord/Hydromyelia
Mild Traumatic Brain Injury

Other

Age - less than 3 years
Indwelling Catheters/Medical Equipment
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Weight Control Disorder
Substance Abuse
Thought Control Disorders
Psychological/Psychiatric Diagnosis

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 the center at (702) 219-1728 or (702) 562-9434, Spirit Therapies, 9140 La Madre Way, Las Vegas, NV 89149.

Sincerely,

Laurie Willmott, Executive Director

RIDER'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Date: _____

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

Address _____ City/State _____ Zip Code _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Yes No

Date of Last Seizure: _____

Shunt Present: Yes No Date of last revision: _____

Special Precautions/Needs: _____

Mobility:

Independent Ambulation: Yes No Assisted Ambulation: Yes No Wheelchair: Yes No

Braces/Assistive Devices: _____

For those with Down syndrome: AtlantoDens Interval X-rays:

Date: _____ Result: Positive Negative

Neurologic Symptoms of AtlantoAxial Instability: _____

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

Auditory: Yes No Comments: _____

Visual: Yes No Comments: _____

Tactile Sensation: Yes No Comments: _____

Speech: Yes No Comments: _____

Cardiac: Yes No Comments: _____

Circulatory: Yes No Comments: _____

Integumentary/Skin: Yes No Comments: _____

Immunity: Yes No Comments: _____

Pulmonary: Yes No Comments: _____

Neurologic: Yes No Comments: _____

Muscular: Yes No Comments: _____

Balance: Yes No Comments: _____

Orthopedic: Yes No Comments: _____

Allergies: Yes No Comments: _____

Learning Disability: Yes No Comments: _____

Cognitive: Yes No Comments: _____

Emotional/Psychological: Yes No Comments: _____

Pain: Yes No Comments: _____

Other: _____

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the NARHA center will weigh the medical information above, against the 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Name/Title: _____ MD DO NP PA Other: _____

Signature: _____ Date: _____

Address: _____ City/State _____ Zip Code _____

Phone: () _____ License/UPIN Number: _____

RELEASE OF LIABILITY

The undersigned is a business guest and/or patron and/or visitor, or is the owner of a horse(s) kept upon the premises at 9140 La Madre Way, Las Vegas, Nevada, 89149 and fully understands that there is a certain amount of inherent danger in the keeping, handling, owning, riding, and being in the presence of horses, and in consideration of the owner/renters/guests, Jeff and Laura Willmott, permitting the undersigned to keep, board, ride, or train a horse(s) on said premises, or in consideration of permission granted to the undersigned and guests to visit upon said premises, or to receive any and all types of equestrian instruction upon said premises, the undersigned and guests, do hereby agree to assume all risk to loss, injury, or illness to all horses belonging to the undersigned, and to assume all loss, damage, or injury to any equipment or personal property to the undersigned.

Furthermore, the undersigned does hereby agree to assume all risk of personal injury to the undersigned, or guests of the undersigned, at any time while at the location of 9140 La Madre way, and does hereby release owners/renters/guests/Jeff and Laura Willmott, agents, employees, and staff, from any and all liability occurring from damage to or loss of property or equipment, or injury to or illness of any horse(s) or animals of the undersigned while at/on said property, facility and premises. The undersigned does hereby waive any and all claims of any and every kind of nature growing out of or based upon the operation of the aforementioned property, owners/renters/guests, and Jeff and Laura Willmott, agents, employees, and staff.

THE UNDERSIGNED HAS READ AND FULLY UNDERSTANDS THE CONTENTS OF THIS RELEASE OF LIABILITY AND BY SIGNING BELOW AGREES TO COMPLY AND BE BOUND BY THE CONTENTS STATED WITHIN.

Dated this _____ Day of _____ 20____

Signature: _____

Printed Name: _____

Address: _____

City/State: _____ Zip Code: _____

Cell Phone: _____ 2nd Phone: _____

Witness Printed Name: _____

Witness Signature: _____