

**Briggs Stable**  
**Therapeutic Riding Division**

623 Hanover Street, Rte. 139

Tel: 781-826-3191

Fax: 781-829-0091

**Statement of Participant Eligibility**

Briggs Stable Therapeutic Riding Division offers Therapeutic Riding Services to individuals with special needs. Eligibility for participation in the Therapeutic Riding Section of Briggs Stable's lesson program is based on the individual's ability to participate meaningfully and SAFELY, provided there is a NARHA (North American Riding for the Handicapped) Certified Instructor and an appropriately sized horse to accommodate the individual needs of the rider.

Briggs Stable has on staff NARHA Certified Instructors and NARHA members, therefore, Briggs Stable adheres to the precautions and contraindications as recommended by the Medical Committee of NARHA. Briggs Stable's therapeutic riding instructors also adhere to the code of Ethics set by NARHA. For that reason, all prospective riders are evaluated by our professional staff before they are accepted into therapeutic riding lessons.

There are individuals whom the Briggs Stable Therapeutic Riding programs are deemed inappropriate due to the nature of therapeutic riding. This determination is made on the basis of physical/behavioral limitations, recommendations from their professional medical advisors or the inability for Briggs Stable to presently provide the steed or equipment necessary to complete safe/effective lessons. Determinations of this kind will be made during the initial orientation/ assessment.

In accordance to NARHA standards, riders accepted into the program are required to take part in periodic progress reviews. During these reviews, or following any unusual incidences during a lesson, Briggs professional staff may find that continuance in the program is inappropriate. Therefore, Briggs Stable reserves the right to discontinue the participation of a given individual in its programs when it is deemed that discontinuance is in the best interest of Briggs Stable or the rider concerned.

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## Participation Application

**Warning:** Under Massachusetts Law, an equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities, pursuant to Chapter 128, Section 2D of the General Laws.

### Please Print

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

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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

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

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

\_\_\_\_\_

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

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

Email: \_\_\_\_\_

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

Parent's/ Guardian's Name: \_\_\_\_\_

**\*\*Riders that have allergies to bee stings must bring an epi-pen with them. Please inform the staff about the allergy when you arrive.**

### Additional Information

What are the greatest needs of the participant? \_\_\_\_\_

Does she read/print name? \_\_\_\_\_

Is she mentally impaired? \_\_\_\_\_

Is she physically disabled? \_\_\_\_\_

Is the rider incontinent? \_\_\_\_\_ Bowel? Bladder? Can the rider toilet alone? \_\_\_\_\_

Describe any special procedures or equipment needed: \_\_\_\_\_

Does the rider have a stoma (ostomy)? \_\_\_\_\_ Procedures needed? \_\_\_\_\_

Does the rider use any form of supportive/assistance equipment? \_\_\_\_\_

Signature of Rider/ Guardian: \_\_\_\_\_

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

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## Authorization for Emergency Medical Treatment

In an emergency or 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 Briggs Stable to secure and retain medical treatment and transportation if needed and/or release client records upon request of the authorized individual or agency involved in the medical emergency.

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

Parent/Guardian's Name: \_\_\_\_\_

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

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

\_\_\_\_\_

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

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

In the event of an emergency where the parent or guardian cannot be reached, contact:

1. Name: \_\_\_\_\_

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

Relation: \_\_\_\_\_

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

2. Name: \_\_\_\_\_

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

Relation: \_\_\_\_\_

Cell phone: \_\_\_\_\_

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

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

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

Health Insurance Co: \_\_\_\_\_

Policy #: \_\_\_\_\_

### Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment deemed "life saving" by the physician. This provision will only be invoked if the person listed below is unable to be reached.

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

### Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PLEASE INFORM YOUR EMERGENCY CONTACTS OF YOUR NON-CONSENT CHOICE!!!!!!

Non-Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_