

**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: \_\_\_\_\_

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**Information for Physician**

Below is a list of conditions that need to be taken into consideration before allowing therapeutic horseback riding. These conditions, if present, may bring precautions and/or contraindications to therapeutic horseback riding. Please note on the following form whether or not these conditions are present and to what degree.

**Orthopedic**

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

**Neurologic**

Chiari II Malformation  
Hydrocephalus/ Shunt  
Hydromyelia  
Microcephalus  
Paralysis due to Spinal Cord Injury  
Seizure Disorder  
Spina Bifida  
Tethered Cord

**Medical / Surgical**

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

**Secondary Concerns**

Acute Exacerbation of chronic disorder  
Age: under two years  
Age: two - four years  
Behavioral Problems  
Indwelling catheter  
Severe Psychological Condition

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**Riding Authorization**  
**Riders' Medical History and Physician Statement**

This form must be completed by a licensed physician in order for a rider to participate in therapeutic riding lessons at Briggs Stable. Forms need to be updated annually.

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

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

Rider's Name: \_\_\_\_\_

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

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

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

Parent's Name: \_\_\_\_\_

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

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

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

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

Tetanus Shot: Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_

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

Side effects: \_\_\_\_\_

**FOR RIDERS WITH DOWN SYNDROME ONLY:**

Negative Cervical X-Ray for Atlantoaxial Instability      Yes \_\_\_\_\_ No \_\_\_\_\_

Negative for Clinical Symptoms of Atlantoaxial Instability      Yes \_\_\_\_\_ No \_\_\_\_\_

X-Ray Date: \_\_\_\_\_

Riders and Caregivers are urged to voluntarily enclose an up to date copy of the vaccination records along with this form.

Please indicate if the rider has/had a problem and or surgeries in any of the following areas. If yes, then please provide a comment.

<b>Areas</b>	<b>Yes</b>	<b>No</b>	<b>Comments</b>
Allergies			
Auditory			
Cardiac			
Circulatory - PVD - Postural Hypotension			
Hemophilia			
Hydrocephalus - Shunt			# of revisions:      Date of last revision:
Learning Disability			
Mental Impairment			
Muscular - Contractures			Botox Injections?
Neurological - Seizures - Controlled ?			Last Seizure:
Orthopedic			
Pain - Where - What degree			
Psychological Impairment - Severity - Therapy			Are there any triggers or things to avoid?
Pulmonary - Asthma/ COPD			
Sensory Loss			
Speech			
Visual			Glasses Y_____ No_____
<b>Other</b>			
PLEASE CONTINUE ON TO THE NEXT PAGE			

<b>Skeletal Information</b>	<b>Yes</b>	<b>No</b>	<b>Explain Degree and Comment</b>
*Down Syndrome only* Evidence of Spinal Cord Compression			
Braces			Last X-Ray:
Cranial Defects			
Dislocating Joints			
Fractures - Location - Healed (date)			
Heterothrophis/Ossification			
Joint Disease			
Kyphosis/ Lordosis    Type			Degree:
Laminectomy/Fusion			
Medications			
Osteoporosis			
Subluxing Joints			
Scoliosis/ Degree/ Type			
Spinal Abnormality			
Spinal Column Injury			
Spondylolistheses			
<b>Other</b>			

**Mobility:**

Ambulatory:    Yes \_\_\_\_\_ No \_\_\_\_\_

Independently:    Yes \_\_\_\_\_ No \_\_\_\_\_

Crutches:    Yes \_\_\_\_\_ No \_\_\_\_\_

Braces:    Yes \_\_\_\_\_ No \_\_\_\_\_

Wheelchair:    Yes \_\_\_\_\_ No \_\_\_\_\_

Prosthetics:    Yes \_\_\_\_\_ No \_\_\_\_\_

Purpose: \_\_\_\_\_

Special Precautions: \_\_\_\_\_

Please include any additional information that may help us with our success with your client. Thank you. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Riding Authorization

To be signed by the physician. Stamps are not accepted.

To my knowledge there is no reason why \_\_\_\_\_ cannot participate in supervised equestrian activities and events. However, I understand that the Therapeutic Riding Instructor at Briggs Stable will review and weigh the medical information above against the existing precautions and contradictions set by NARHA. I concur with a review of this person's abilities/limitations by a licensed/ credentialed health professional (PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Please **initial** one of the following options

I **do recommend** horseback riding for the above patient \_\_\_\_\_

I **do NOT recommend** horseback riding for the above patient \_\_\_\_\_

Recommended Frequency: \_\_\_\_\_

Precautions: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Address of Practice: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**BRIGGS STABLE, LLP**  
**GENERAL RELEASE OF LIABILITY AND INDEMNIFICATION AGREEMENT**

I CLASSIFY MYSELF AS A  
BEGINNER [ ] INTERMEDIATE [ ] ADVANCED [ ] RIDER.

<b>RIDER</b>	
NAME _____	EMERGENCY # _____
ADDRESS _____	PERSON TO CONTACT _____
CITY/STATE _____	NAME OF INSURANCE CO. _____
TELEPHONE # _____	POLICY # _____

<b>PARENT/LEGAL GUARDIAN</b>	
NAME _____	ADDRESS _____
TELEPHONE # _____	CITY/STATE _____

This Release and Indemnity Agreement is made and entered into by and between Briggs Stable LLP, a Massachusetts corporation ("Owner"), the undersigned person who wishes to use the property, facilities and services of Owner and, if such person is a minor, his parent or guardian (the undersigned and his parent or guardian are referred to collectively as "Rider"). In consideration of the use, today and on all future dates, of the property facilities and services of Owner, Rider hereby expressly agrees to the following:

1. It is the sole responsibility of Rider to carry full and complete healthcare insurance coverage and loss insurance coverage for his personal property and himself.
2. Rider understands that horseback riding is an inherently dangerous activity. Rider voluntarily assumes **ANY AND ALL RISKS INVOLVED IN OR ARISING FROM RIDERS USE OR PRESENCE UPON OWNER'S PROPERTY AND FACILITIES** including, but not limited to, the risks of death, bodily injury, property damage, falls, kicks, bites, collisions with vehicles, horses or stationary objects, fire or explosion, the unavailability of emergency medical care, or the negligence or deliberate act of Owner or its affiliates or their officers, directors, shareholders, partners, agents, employees and representatives.

**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.**

3. Rider releases, discharges and agrees to indemnify and hold harmless and hold harmless Owner and its affiliates and their officers, directors shareholders, partners, employees, agents and representatives and their respective successors and assigns (collectively, Releases"), from all actions, causes of action, claims, liabilities, judgments, costs expenses and other obligations, whether or not occasioned by any Releasee's negligence, arising out of Rider's use or presence upon Owner's property or facilities, including without limitation, those based on death, bodily injury or property damage. Rider **AGREES NOT TO SUE** any of the Releasees in connection with any claim arising out of Rider's use of or presence upon Owner's property or facilities. The indemnification called for hereunder shall include Rider being responsible for the payment of Owner's attorneys fees and costs.
4. Rider agrees to abide by all of Owners rules and regulations.
5. This Agreement shall be construed so as to permit its enforcement to the fullest extent permissible under the laws of the Commonwealth of Massachusetts. If any provision hereof is held invalid or unenforceable, the remaining provisions shall be given effect without regard to the invalid or unenforceable provision. This Agreement shall be governed by the laws of the Commonwealth of Massachusetts without regard to its conflict of laws rules. Rider hereby consents and submits to the exclusive jurisdiction and venue of the courts located in the County of Plymouth, Commonwealth of Massachusetts in connection with any action or proceeding arising out of or relation to this agreement. This Agreement may not be changed other than by writing specifically referring to this document and signed by a duly authorized officer of Owner. This Agreement shall be binding upon rider's spouse heirs, successors, executors, administrators and legal representatives.

**THIS DOCUMENT IS THE PROPERTY OF BRIGGS STABLE, LLP AND WILL REMAIN IN FORCE UNTIL SPECIFICALLY WITHDRAWN BY ALL PARTIES HERETO.**

*By Signing the line below you are acknowledging that you have read and understood the above release and indemnity agreement.*

Date \_\_\_\_\_ **X** \_\_\_\_\_

I hereby consent to any medical, dental or surgical treatment or procedure of an emergency nature that is reasonably necessary to save the life of the rider named above or to restore the Rider to health.

Date \_\_\_\_\_ Riders Signature **X** \_\_\_\_\_

Date \_\_\_\_\_ Parent/Legal Guardian Signature \_\_\_\_\_