PO Box 721, Zionsville, IN 46077
Tel: (317) 769-5161
www.morningdovetrc.org

Dear Prospective Rider:

We are very excited about your interest in Morning Dove. There are a few things that you will need to do before beginning. You will need to complete a New Rider Packet including: registration, physician release and general release forms as well as a class preference form. They are all available on our website. If you do now have access to the internet, please let us know and we will be happy to mail them to you. Simply download the forms, complete them and mail them in. All forms need to be completed and returned prior to the visit. Please note that the Physician Statement must be signed by your child's physician.

If you have a delay in completing your physician's release, you may mail in the class preference form separately as soon as possible. Once all forms have been returned, we will contact you regarding your visit and set up an assessment. In order to maintain the highest safety standards there are several factors that must be taken into consideration before accepting a new student into the program. These include; medical condition, behavioral issues, weight and height, availability of a suitable horse and availability of volunteers to assist. The first visit to Morning Dove will be an evaluation assessment. This is a short lesson which helps us to determine the appropriate horse, support needs and suitable class for the rider. We want to ensure that every match is safe and appropriate for each rider. After the assessment you and the instructor will discuss class times that best meet the rider's needs and your schedule. If all available classes are filled, we do have a waiting list option.

Our sessions are 8-10 weeks in length and fees are based on a tuition schedule due before the first lesson of each session. Each class costs us $50 per student. Through scholarships and donations we are able to offer classes to our students for only $20 a lesson. If you have a financial need, please call our office and we will work with you to make appropriate arrangements. If our session is full we do offer a wait list and will try to accommodate you as soon as possible.

As of January 2007, we will have moved to a new location conveniently located just off of Highway 65 and the Zionsville exit. We will be at this location for the next couple of years as we build our new state of the art facility. This will allow us to expand our program to more riders and offer all of our services at one site. If you have questions about some of our other programs please visit our website or call us for more information. We look forward to working with you and welcome you to the Morning Dove family!!!

Sincerely,

Janice S. Helsper	Blair McKissock
Executive Director Morning Dove Therapeutic Riding Inc.	Program Director

MORNING DOVE THERAPEUTIC RIDING, INC.
PO Box 721, Zionsville, IN 46077
Telephone (317) 769-5161

Participant Registration and Health History

General Information

Participant:____
DOB: __________ Age: ___________ Height __________ Weight: _______ Gender: M F
Address:____
Phone:______________________________County:_____________________________
Alternative Phone:___________________________ E-Mail: _________________________
Ethnicity (optional, for grant purposes only) African American____ Asian_____ Hispanic_____
Caucasian______ Native American_____ Other_______

Employer/School:____
Address:____
Phone:_________________________________ E-Mail:____________________________

Parent/Legal Guardian:____
Address (If different from above):____
Phone:_________________________________ E-Mail:____________________________
Profession____

How did you hear about us? ____

Health History

Diagnosis____
____
Date of Onset:_____________________________

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

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

Medications (include prescription, over-the-counter; name, dose, and frequency)____

____

____

____

____

Describe your abilities/difficulties in the following areas (include assistances required or equipment needed):

Physical Function (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

____

____

____

____

____

____

Psycho/Social Function (i.e. Work/school including grade completed, leisure interest, relationships-family structure, support systems, companion animals, fears/concerns, etc)

____

____

____

____

____

____

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

____

____

____

____

____

____

Rider's Interests

Are you comfortable working or walking around horses / ponies? ___________

Do you have experience with horses or ponies? _____ If so, specify ________________________

____

Have you had any riding experience? _________ Describe: ________________________________

____

Have you done any grooming or tacking of horses or ponies ? ______________________________

____

Favorite Color__________________________________

Favorite TV show________________________________

Favorite Movie__________________________________

Favorite Game__________________________________

Favorite Sport___________________________________

Favorite Animal__________________________________

Favorite Type of Music/Songs____

Any Pets (If yes, names please)____

Hobbies____

____

Please list any dislikes or discomforts of the rider (i.e. fears)

____

____

Do you or your family have any other skills or training which you think could help with the mission of Morning Dove? ____

____

Referrals

Do you know of anyone who might be interested in participating with Morning Dove as a rider, volunteer or donor? Please let us know and we will add them to our newsletter.

Name:__________________________________Phone:_____________________________________
Email Address:_________________________Interest: Rider_____Volunteer:____Other:_________

Name:__________________________________Phone:_____________________________________
Email Address:_________________________Interest: Rider_____Volunteer:____Other:_________

Name:__________________________________Phone:_____________________________________
Email Address:_________________________Interest: Rider_____Volunteer:____Other:_________

Name:__________________________________Phone:_____________________________________
Email Address:_________________________Interest: Rider_____Volunteer:____Other:_________

MORNING DOVE THERAPEUTIC RIDING INC.

RIDER'S EMERGENCY MEDICAL RELEASE FORM

RIDER'S NAME ____

PARENT / GUARDIAN____

ADDRESS ______________________ CITY _________________ STATE ______ ZIP ______

PHONE ___________________________________ DOB ______________________________

WORK PHONE _______________________ Email Address ______________________________

RIDER'S DISABILITY ________________________ DATE OF ONSET _________________

PHYSICIAN'S NAME ___________________________ ADDRESS_____________________

PHYSICIAN'S PHONE _________________________________

Person who is authorized to give temporary assistance or care in absence of parent or guardian:

____
(Name) (Phone) (Relationship)

Preferred Medical Facility:____

Describe any medical condition requiring special precautions or treatment and any medications and dosage:
(A)None ____________(B)Please describe:____

In case of medical emergency, the undersigned authorizes Morning Dove Therapeutic Riding Inc. to provide such medical assistance as they determine to be necessary.

The undersigned authorizes any licensed physician and / or medical facility to provide any medical / surgical care and / or hospitalization for the rider, including anesthetic, which they determine necessary or advisable, pending receipt of a special consent form from the undersigned.

No person can be accepted for riding instruction until this form has been completed by the parent / parents or guardian. If the person is of legal age (18), he or she may complete the form, if he or she is legally competent to do so. Riding instruction will be under strict supervision, and although every effort will be made to avoid any accident, NO LIABILITY can be accepted by any of the organizations concerned, including Morning Dove Therapeutic Riding Inc.

Yes, I would like ____ to have riding instruction, and I have discussed this with the rider's doctor. I understand that NO LIABILITY can be accepted by any organizations concerned, including Morning Dove Therapeutic Riding Inc., in the event of any accident which may occur.

____
SIGNATURE OF PARENT / PARENTS OR GUARDIAN

____
SIGNATURE OF RIDER IF OVER AGE 18

PARENT / GUARDIAN RELEASE AGREEMENT FOR MORNING DOVE THERAPEUTIC RIDING INC.

The undersigned, as parent / parents and / or guardian / guardians of ____, a minor, for and in consideration of the agreement with Morning Dove Therapeutic Riding to provide riding instruction to said minor, does / do hereby forever release, acquit, discharge and hold harmless Morning Dove Therapeutic Riding, 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 or said minor may now, or in the future, have against Morning Dove Therapeutic Riding, its officers, trustees, agents, employees, representatives, successors and assigns, on account of any personal injuries, physical or mental condition, known or unknown, to the person of said minor and the treatment therefore as a result of, or in anyway growing out of, the acts of Morning Dove Therapeutic Riding, 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 or in anyway incidental thereto. Under Indiana 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.

I have read and understand this release.

DATE: ___________________________________

SIGNED: ___________________________________ WITNESSED:____
Parent(s) / Guardian(s)

PHOTO RELEASE FORM

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grant to Morning Dove Therapeutic Riding permission to take or have taken, still and moving photographs and films including television pictures of ______________________________________ and consents and authorizes Morning Dove Therapeutic Riding , its advertising agencies, news media, and any other persons interested in Morning Dove Therapeutic Riding, and its work, to the use and reproductions of the photographs, films, and pictures to circulate and publicize the same by all means including without limit, the generality of the foregoing newspapers, television media, brochures, pamphlets, instructional materials, books and clinical material.

With regard to the foregoing material, no inducements or promises have been made to us / me to secure our / my signature(s) to this release other than the intention of Morning Dove Therapeutic Riding to use or be used such photographs, films and pictures for the primary purpose of promoting and aiding its program and its work.

I have read and understand this release.

Dated this _____________ day of ________________, __________.

Signed ____

MORNING DOVE THERAPEUTIC RIDING, INC
Po Box 721, Zionsville, IN 46077
Telephone: (317) 769-5161

Participant's Medical History & Physician's Statement

Participant:__________________________DOB:___________Height:______Weight: _______
Address:____
Diagnosis:____
____ Date of Onset:_________
Past / Prospective Surgeries: ____
Medications:____
Seizure Type: ___________________________________ Controlled: Y N
Date of Last Seizure: ________________
Shunt Present: Y N Date of last revision: ______________________________________
Special Precautions/Needs: ____
____
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices:____
For those with Down Syndrome: Atlanto Dens Interval X-rays,
date:________________________ Results: + -
Neurological Symptoms of Atlanto Axial Instability:____________________________________

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

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Incontinence (Other)			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

General Comments:____
____
____
____
____
____

To my knowledge, there is no reason why this person cannot participate in supervised equestrian 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:____
Phone:_______________________ License/UPIN Number______________________________