2025 Lesson Season:
One-Time Riders Reservation Form

Please send your completed packet to:

High Hurdles Therapeutic Riding Center
ATTN: Shelby Dytschkowskyj
13339 Rt 39
Sardinia, NY 14134

OR

Email to shelby.dytschkowskyj@sasinc.org

OR

Fax to 716.496.4010

QUESTIONS?

Office Phone 716.436.3935
Barn Cell 716.548.0004

Rider Name _____
Phone # (if applicable)_____Text? o YES o NO
Email _____
Address _____
City/State _____ Zip _____
Contact Person _____
Relationship to rider _____
Phone #_____ Text? o YES o NO Email _____
Parent or Legal Guardian (circle one) _____
Phone # _____ Text? o YES o NO Email _____
Address _____
City/State _____ Zip _____
For High Hurdles correspondence (including lesson cancellation), who is best person to contact?
o RIDER via o text o call o email
o CONTACT PERSON via o text o call o email
o PARENT/GUARDIAN via o text o call o email

Please indicate to whom the invoice should be sent:

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Email: _____

2025 Lesson Season: Rider Information/Background

Please complete this section as completely and accurately as possible to ensure the safety of the rider, horse and staff and to allow us to serve the rider as effectively as possible.

Rider Name: _____Date of Birth: _____
Height: _____
Weight: _____ (required) *We have a strict 200lb on-horse weight limit.
Gender: _____
Diagnoses: _____
Medical/Surgical History:
_____
Current Medications:
_____
Adaptive Equipment:
_____

ABILITY **Please mark an X in each box, or further comment**	**TOTAL ASSISTANCE**	**NEEDS SOME ASSISTANCE**	**INDEPENDENT/ SUPERVISION**
Stair Climbing			
Mobility			
Transferring			
ADL Skills (grooming, dressing, etc.)			
BALANCING	**POOR**	**FAIR**	**GOOD**
While seated			
While standing			
While moving			
MOTOR SKILLS	**POOR**	**FAIR**	**GOOD**
Head Control			
Trunk Control			
Grip strength			
Muscle Strength			
Range of Motion in Arms			
Range of Motion in Legs			

2025 Lesson Season: Release Forms

Rider's Name: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____ Phone: _____

Health Insurance Company: _____ Phone: _____

List all pertinent medical information (allergies to food or drugs, special medical conditions): _____

Select One:

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 the agency, I authorize Suburban Adult Services, Inc. to:

- Secure and retain medical treatment and transportation if needed.
- Release rider records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the contacts listed above are unable to be reached.

_____

Consent Signature Date

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 Suburban Adult Services, Inc. In the event emergency treatment is required, I wish the following procedures to take place:

_____

_____

_____

_____

_____

_____

_____

_____

Non-consent Signature Date

LIABILITY RELEASE

_____ (Rider's Name) would like to participate in the High Hurdles Therapeutic Riding Program. I acknowledge the risks and potential for risks of horses and 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 bound, for myself, my heirs and assigns, executors, or administrators, waive and release forever all claims for damages against Suburban Adult Services, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in High Hurdles Therapeutic Riding Program.

Signature: _____ Date: _____

Parent / Guardian / Correspondent / or Rider (if over 21, no guardian)

PHOTO RELEASE (optional)

I hereby consent to and authorize the use and reproduction by Suburban Adult Services, Inc., of any and all photographs and any other audio / visual materials taken of me/my son/my daughter/ my ward for promotional printed material, social media, website, educational activities or for any other use for the benefit of the program.

Signature: _____ Date: _____

Parent / Guardian / Correspondent / or Rider (if over 21, no guardian)

2025 Lesson Season: Physician Release Form

Dear Dr. _____,

Your patient _____has shown an interest in participating in our therapeutic horsemanship/riding program. In order to safely provide this service, our center requests that you complete/update this Medical History and Physician's Statement Form. Please provide us with your recommendations regarding the activity/exercise prescription for this individual and any restrictions and/or limitations that would limit their participation in this program. Please note that the following conditions may suggest precautions and contraindications to equine activities - please indicate whether these conditions are present and to what degree. Thank you for your time and cooperation in completing this form.

Orthopedic
Atlantoaxial Instability- include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation
Tethered Cord/Hydromyelia

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire setting
Hemophilia
Medical Instability
Migraines
PVD
REspiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders

Other
Weight Control Disorder
Age- under 4 years
Indwelling Catheters/Medical Equipment
Medications - e.g. photosensitivity
Poor Endurance
Skin Breakdown

Diagnoses: _____

Past / Prospective Surgeries: _____

Seizures / type? _____ Controlled? o YES o NO Date of last seizure: _____
Down syndrome? o YES o NO
If YES, date of cervical spine x-ray: _____ Result: _____ (must be negative to ride)
Shunt present? o YES o NO
Please check any limitations to any muscle strength activation movements or limited mobility:
Chest: _____ Shoulders: _____ Back: _____ Hips: _____ Biceps: _____ Legs: _____
Limitations to any cardiovascular/endurance training exercises, primarily during periods of walking/jogging? o YES o NO

Other limitations/restrictions to on-horse/riding activities? o YES o NO Please specify any that are appropriate:
_____
Physician's Recommendation
o I am not aware of any contraindications in participating in this horsemanship program
o I believe this individual can participate on horse, but urge caution because:
_____
o This individual should NOT participate in ON-HORSE/Riding activities, but MAY participate in OFF-HORSE activities:
_____
o I recommend this individual NOT participate in the program.

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted services/activities. I understand that High Hurdles Therapeutic Riding Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to High Hurdles Therapeutic Riding Center for ongoing evaluation to determine eligibility for participation.

Signature: _____ Date: _____