

TEAM

(Therapeutic Equine Activity Member)

Dear Riders/Parents:

It is registration time at Mississippi State University for the 4-H TEAM Program!

This information is intended to assist you in completing the enclosed paperwork. Please understand that this paperwork is necessary for the 4-H TEAM Program to be in compliance with NARHA accreditation standards.

Session Registration Form: This form applies to the year _____ Session.

Rider's Medical History & Physician's Statement: Requires a doctor's signature on office stationary, and is submitted once yearly. This is a two-page form. Riders cannot participate in any mounted riding activity at TEAM without this form.

Activity Participation Agreement: Riders cannot participate in any activity at TEAM without this form.

Photo Release/Non-Consent: Required for participation. We must know your position regarding photography.

Emergency Medical Authorization Non-Consent Form: All participants and volunteers who participate in the TEAM program must sign consent for emergency medical treatment or a non-consent plan for emergency medical treatment which will be kept on file.

Please note that if the participant is under 21 years of age, then the signatures of both parents are required on the emergency medical consent form. If there is only one parent, or if there is a court order awarding custodial rights to one parent, then only that parent's signature is required. If a custodial parent or guardian is physically present during an activity, then that person must take responsibility for securing emergency medical treatment in the event of an accident or illness.

Fees Classes are _____ each, to be paid in full prior to session. All forms and rider fees must be completed, signed, and returned by _____ in order to participate in the TEAM session scheduled for _____. Please make checks payable to:

TEAM
State 4-H Youth Development Office
Box 9641
Mississippi State, MS 39762

Explanation of Services

Therapeutic Riding-- certified therapeutic riding instructors teach one-hour group lessons. The emphasis is on riding skills development. Maximum class size is four riders.

Hippotherapy-- Hippotherapy is clinical physical therapy using the horse as a treatment tool.

To be in compliance with national standards, we have established the following criteria for participation in therapeutic riding classes.

Minimum Age: 4 years old for therapeutic riding classes
2 years old for hippotherapy

Additionally, in keeping with our veterinarians' recommendations, the following rider weight limits have been established:

Height	Maximum Weight
Under 5' tall	150 pounds
5'-5'6" tall	175 pounds
5'6"-6" tall	200 pounds
6'5"-6'5" tall	250 pounds

Classes will be filled on the basis of disability needs, riding ability, and volunteer ability. Please encourage individuals who are interested in volunteering to contact the MSU State 4-H Department Office. The lack of volunteers is often the only impediment to confirming a scheduled class. There is a great need for committed volunteers!

TEAM Admission and Discharge Policy

It is the decision of the Program Coordinator/Instructor to admit or discharge a rider. The age and weight charts are given on the rider application. Riders can be discharged from the TEAM Program for other reasons, such as failure to appear for classes, inappropriate behavior, or implications that the continuation of therapeutic riding is a contraindication.

A rider possessing the ability and desire to advance to a higher level of instruction than the TEAM Program offers will be discharged and given assistance in locating a program and/or instructor that meets their needs.

It is MANDATORY that all riders, volunteers, and staff ride with (ASTM-SEI) helmets or NARHA approved alternative guidelines.

Safety stirrups or hard sole shoes or boots with heels are MANDATORY for all riders, volunteers, and staff. Stirrups and footwear must be approved by the instructor before mounting.

We look forward to having you with us to ride!

Sincerely,

Mary Riley
State 4-H Therapeutic Riding Program Instructor

MR/mj

MISSISSIPPI STATE UNIVERSITY
ACTIVITY PARTICIPATION AGREEMENT

In consideration for participating in the Mississippi State University 4-H TEAM Program (hereinafter "Activity") and other valuable consideration, I hereby RELEASE, WAIVE, and DISCHARGE Mississippi State University, the Board of Trustees of State Institutions of Higher Learning for the State of Mississippi, the State of Mississippi, their officers, servants, agents, and employees (hereinafter "RELEASEES") from any and all liability, claims, demands, actions, and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by me, or to any property belonging to me. WHETHER CAUSED BY THE NEGLIGENCE OF, OR A BREACH OF ANY EXPRESS OR IMPLIED CONTRACT BY, THE RELEASEES, OR OTHERWISE, WHILE PARTICIPATING IN SUCH Activity, or while in, on or upon the premises where the Activity is being conducted or while in transit during and to and from said Activity. I further acknowledge that the Releases, as public entities, do not carry liability insurance for this Activity and that in order to provide this Activity, and others like it, as part of the Releasees' educational program, it is essential that the Releasees not be subject to liability or such Activities sponsored by the Releasees may not be feasible in future public educational programs offered by the Releasees.

To the best of my knowledge, I can fully participate in this Activity, I am fully aware of the risks and hazards connected with the Activity, and I hereby elect to voluntarily participate in said Activity, and to engage in such Activity knowing that the Activity may be hazardous to me and my property. I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISKS OF LOSS, PROPERTY DAMAGE, OR PERSONAL INJURY, INCLUDING DEATH, that may be sustained by me, or any loss or damage to property owned by me, as a result of being engaged in such Activity.

I further hereby COVENANT NOT TO SUE the Releasees and AGREE TO INDEMNIFY AND HOLD HARMLESS the Releasees from any loss, liability, damages, or costs, including, but not limited to, court costs and attorney's fees, that may result from my participation in said Activity.

It is my express intent that this Activity Participation Agreement shall bind the members of my family and spouse (if any), if I am alive, and my heirs, assigns, and personal representative if I am not alive, and this Agreement shall be deemed as a RELEASE, WAIVER, DISCHARGE, INDEMNIFICATION, AND COVENANT NOT TO SUE the above RELEASEES. I hereby further agree that this Agreement shall be construed in accordance with the laws of the State of Mississippi.

I further understand that the Releasees are not responsible for any medical costs associated with any injury or illness I may sustain resulting from my participation in this Activity.

WARNING

Under Mississippi law, an equine activity or equine sponsor 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 this chapter.

IN SIGNING THIS RELEASE, I ACKNOWLEDGE AND REPRESENT THAT I have read the foregoing Activity Participation Agreement, that I understand it, that I sign it voluntarily as my own free act and deed, and that no oral or written representation or statements of inducements, apart from the foregoing written agreement, have been made. If I am under twenty-one (21), I understand that a parent or guardian must also sign this Agreement indicating their separate and complete obligation to adhere to the terms of this Agreement. I execute this Agreement for full, adequate, and complete consideration fully intending to be bound by same.

Participant's Signature Date

Parent/Guardian Signature Date

Parent/Guardian Signature Date

TEAM Rider Application Form—(cont'd)

(Please type or print)

What medications are you currently taking, including over-the-counter medications?

Describe your abilities/difficulties in the following areas (include whether assistance is required or if equipment is needed):

FUNCTION (i.e. mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

SOCIAL (i.e. work/school including grade completed, leisure interests, 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?)

INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

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

Neurologic

- Hydrocephalus/shunt
- Spina Bifida
- Tethered Cord
- Chiari II Malformation
- Hydromyelia
- Paralysis Due to Spinal Cord Injury
- Seizure Disorders

Medical/Surgical

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

Secondary Concerns

- Behavior Problems
- Age under Two Years
- Age Two to Four Years
- Acute Exacerbation of Chronic Disorder
- Indwelling Catheter

TEAM
Rider's Medical History and Physician's Statement
(To be completed annually by physician)

Name _____ Date of Birth _____

Address: _____

Name of Parent/Guardian: _____

Diagnosis _____ Date of On-set _____

**The following questions apply to persons with Down's Syndrome.

Negative Cervical X-ray for Atlantoaxial Instability Yes No X-ray Date _____

Negative for clinical symptoms of Altantoaxial Instability Yes No

Tetanus Shot Yes No Date _____ Height _____ Weight _____

Seizure Type _____ Controlled _____ Date of last seizure _____

Medications _____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking "yes" or "no." If "yes," please comment.

Areas	Check One	Comments
Auditory	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Visual	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Speech	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cardiac	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Circulatory	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pulmonary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Neurological	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Muscular	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Orthopedic	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Learning Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mental Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychological Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	

TEAM

Rider's Medical History and Physician's Statement *(cont'd)*

Mobility (*check one*) Independent Ambulation? Yes No Crutches? Yes No
 Braces? Yes No Wheelchair Yes No

Please indicate any special precautions _____

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weight the medical information above and against the existing precautions and the contraindications. I concur with a review of this person's abilities/limitations by a licensed/credential health professional (e.g. PT, OT, Speech Therapist, Psychologist, etc.) in implementing of an effective equestrian program.

Physician Name (*please print*) _____

Physician Signature _____

Address _____

City _____ State _____ Zip _____

Phone (_____) _____ Date _____

TEAM Prescription

Client's Name _____ Phone _____

Prescription for Therapeutic Horseback Riding

Prescription where appropriate for evaluation and treatment by a Physical, Occupational, and/or Speech Therapist in conjunction with the Therapeutic Horseback Riding Operating Center.

Recommended Frequency _____

Precautions _____

Physician's Signature _____ Date _____

Physician's Name _____

(Please print, type or stamp)

Address _____

Phone _____

Consent for Emergency Medical Treatment

(See next page for Non-Consent for Emergency Medical Treatment)

Rider Name _____ Date of Birth _____

Parent/Guardian: _____

Address _____
Street City State Zip

Telephone _____
Home Phone Work Phone Cell Phone

Rider's Disability _____ Date of On-set _____

Physician's Name _____

Address _____

Telephone _____

Preferred Medical Facility _____

Does the rider have any medical condition(s) requiring special precautions or treatments and any medications and dosage? Yes No If you answered "yes," please describe: _____

In case of medical emergency, the undersigned authorizes Mississippi State University, acting through the adult on its staff who has actual care, control, and possession of the child, to consent to medical, dental, and surgical treatment of the child when the undersigned cannot be contacted. The undersigned represents to Mississippi State University that he or she is the child's parent and either (a) is not divorced from the other parent, or (b) is divorced from the other parent, but has been authorized by a written court order to give consent to medical and dental care and surgical treatment of the child. The undersigned will indemnify and hold Mississippi State University, its officers, members, employees, and agents harmless if he or she is not empowered by law to give this consent.

The undersigned authorizes any licensed physician and/or medical facility to provide any medical/surgical care and/or hospitalization for the child, including anesthetic, which they determine necessary or advisable, pending receipt of a special consent 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 (21), he or she may complete the form, if he or she is legally competent to do so. Although every effort will be made to avoid any accident, NO LIABILITY can be accepted by Mississippi State University.

Yes, I would like _____ to have riding instruction at MSU 4-H TEAM Program. If my child is a rider, I have discussed this with their physician. I understand that NO LIABILITY can be accepted by Mississippi State University, in the event of any accident which may occur.

Signature of Parent/Parents or Guardian

Date

Signature of Rider Over Age of 21

Date

Rider/Parent Insurance Carrier _____

Policy Number _____

Non-Consent for Emergency Medical Treatment

(Please note that you will *NOT* need to complete this Non-Consent for Emergency Medical Treatment Form *IF* you have already completed and signed the Consent Form on Page 10).

Rider Name _____ Date of Birth _____

Parent/Guardian: _____

Address _____
Street City State Zip

Telephone _____
Home Phone Work Phone Cell Phone

I do not give my consent for emergency medical treatment/aid in the event of illness or injury during the process of receiving services or any participation on my part in the MSU TEAM Program. In the event emergency is required. I authorize Mississippi State University or its representative to take the following action in my behalf.

Please notify the following individual(s) in the event of an emergency:

Name Phone (Home) _____
Phone (Work) _____
Phone (Cell) _____

Name Phone (Home) _____
Phone (Work) _____
Phone (Cell) _____

No person can be accepted for participation in the MSU TEAM Program until either this form *or* the Consent for Emergency Medical Treatment form has been completed. If the person is of legal age (21), he/she may complete the form. If the person is not of legal age, the form must be completed by the parent(s) or guardian. Activities will be supervised, and although every effort will be made to avoid any accident, **NO LIABILITY** can be accepted by Mississippi State University.

Signature of Parent or Guardian

Date

Signature of Parent or Guardian

Date

Signature of Rider Over Age of 21

Date

TEAM
Rider's Consent for Release of Information

I hereby authorize _____
(Person or Facility)

to release information from the records of _____
(Client's Name)

The information is to be released to _____
(Operating Center's Name)

For the purpose of developing a Therapeutic Riding Program for the above-named student. The information to be released is marked below.

- _____ Medical history
- _____ Physical therapy evaluation, assessment, and program plan
- _____ Occupational therapy evaluation, assessment, and program plan
- _____ Speech therapy evaluation, assessment, and program plan
- _____ Classroom Individual Education Plan (I.E.P.)
- _____ Other

Signature _____ Date _____
(Client, Parent, or Guardian)

Please send the indicated material to _____
(Operating Center's Name)

Dear Rider and Parents:

As you are well aware, volunteers make your riding lessons possible by serving as your leaders and as your side walkers.

With the growth of our program comes the need for additional volunteers, and we are presently seeking to make contacts with organizations for recruiting purposes. We need your help and your contacts to keep the TEAM Program going strong, and to provide you with a quality program in the coming years.

Please complete the form below and return it to me, Mary Ford, 4-H Therapeutic Riding Instructor, Box 9641, Mississippi State, MS 39762. If you have any questions, please contact me by calling 662.325.1695.

We look forward to having your help in recruiting new volunteers for the TEAM Program! Thanks for all of that you do, and we look forward to hearing from you!

Sincerely,

Mary Ford
4-H TEAM Coordinator

Your Name _____ Phone (home) _____
 Phone (work) _____
 Affiliations (please circle all that apply) Phone (cell) _____

Corporate	Professional	Service Organization	Church	School	Other
Affiliation _____					
Contact _____					
Phone _____					

- _____ I will contact this organization about volunteer opportunities.
- _____ I would like the 4-H TEAM to contact this organization about volunteer opportunities.
- _____ TEAM can use my name when contacting this organization.
- _____ Please *do not* use my name when contacting this organization.

Your Name _____ Phone (home) _____
 Phone (work) _____
 Affiliations (please circle all that apply) Phone (cell) _____

Corporate	Professional	Service Organization	Church	School	Other
Affiliation _____					
Contact _____					
Phone _____					

- _____ I will contact this organization about volunteer opportunities.
- _____ I would like the 4-H TEAM to contact this organization about volunteer opportunities.
- _____ TEAM can use my name when contacting this organization.
- _____ Please *do not* use my name when contacting this organization.

(Please sign one or the other)

CONSENT FOR PHOTO RELEASE

Name of Rider _____

For valuable consideration, given and which is hereby acknowledged, the undersigned hereby grants to Mississippi State University permission to take or have taken still and moving photographs and films, including television pictures and consents and authorizes Mississippi State University, its advertising agencies, news media, and any other persons interested in Mississippi State University and its work, to use and reproduce the photographs, films, or pictures and to circulate and publicize the same by all means, including without limiting the generality of the foregoing, newspapers, television media, brochures, pamphlets, instructional materials, books, and clinical materials.

With respect to the foregoing matters, no inducements or promises have been made to secure this signature to this release other than the intention of Mississippi State University to use or cause to be used such photographs, films, and pictures for the primary purpose of promoting Mississippi State University to its work.

PLEASE SIGN HERE _____
(Adult Rider or Parent/Guardian of Minor Rider)

Date

NON-CONSENT FOR PHOTOGRAPHY

The undersigned withholds permission to Mississippi State University to take or have taken still and moving photographs and films, including pictures.

PLEASE SIGN HERE _____
(Adult Rider or Parent/Guardian of Minor Rider)

Date

Please check to make certain you have completed the enclosed forms before sending in your check.

Form Name	Check if Completed and Enclosed
TEAM Rider Application—Pages 4-5	
Activity Participation Agreement—Page 3	
Medical History/Physician’s Statement—Pages 7-8	
Prescription—Page 9	
Consent for Emergency Medical Treatment—Page 10	
Photo Release—Page 14	
Rider’s Consent for Release of Information—Page 12	

