



## STUDENT REGISTRATION PACKET

**Dreamquest Therapeutic Riding** is a recreational riding program offering horseback riding lessons and equine assisted activities. **Dreamquest Therapeutic Riding** is dedicated to addressing the needs of individuals with cognitive, emotional and behavioral challenges, as well as those individuals with physical disabilities. It is our mission to stimulate personal growth and enhance learning through recreational equine experiences. Learning riding skills is an important part of our program, but there are other benefits our participants experience. Lessons include horsemanship skills such as grooming, tacking up, and general horse care, as well as time on a horse.

### What is therapeutic riding?

Therapeutic use of the horse involves the whole person – mind, body and spirit. Horseback riding has been shown to improve posture, balance, and self-esteem while fostering personal growth. The horse often serves as a strong motivator in helping these individuals work through challenges to improve the quality of their lives. Please visit our web site for more information. <http://www.dreamquesttr.com>.

**What is NARHA?** *(For more information on NARHA, visit their web site at [www.NARHA.org](http://www.NARHA.org)).*

North American Riding for the Handicapped Association, founded over 33 years ago, is a national accrediting organization for therapeutic riding centers, and provides certifications for instructors. Our commitment to excellence is demonstrated through our membership as a NARHA member center and the use of only NARHA certified instructors. This means that **Dreamquest Therapeutic Riding** adheres to NARHA's policies, standards and guidelines for providing a safe and fun environment for equine assisted activities.

### Program Information & Fees:

- Lessons are \$50 per student for a 45 minute lesson.
- Make checks payable to **Dreamquest EFP** at time of lesson
- A Registration Packet (enclosed) must be completed and reviewed prior to riding
- Students will be taught individually or in groups of 2 or 3, as appropriate
- Trained volunteer horse leaders and side-walkers assist with the lesson plan, based on student needs

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Jackie Griswold, NARHA Instructor

Suzane Griswold, NARHA Instructor

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### **Lesson Guidelines:**

Each rider must wear a helmet during the lesson. We do provide helmets at the barn but prefer that students purchase their own. (We can order a helmet for you for \$35.) Students are required to wear long pants for leg protection. We also prefer, if possible, that the student wear hard-soled boots with a heel rather than tennis shoes, to provide ankle support and better placement of the foot in the stirrup.

Parents, please notify your instructor if you omit a dose of your child's regular medication prior to a lesson. Parents or guardians may stay and watch a lesson, but please be courteous and save conversation with your participant or staff until after the lesson to avoid distracting the staff, your participant or the other riders in the class. Parents, siblings or guardians must remain outside of the arena to watch. Children not riding in a lesson must be directly supervised by their parent or guardian, for their own safety and the safety of our riders. Please, no dogs on the property. We ask that you please not feed the horses. Treats for the horses may be given to your instructor to include as part of the lesson plan so that it may be a supervised activity.

### **Cancellation Policy:**

Please make special note that your enrollment in a therapeutic program obligates you to pay each week at the time of the lesson. If you need to cancel a lesson, please do so with at least a 24 hour advance notice directly to your instructor or a message at the farm office; preferably both. **No shows, or notifications less than 24 hours in advance will be charged.** A make up lesson may be scheduled during the upcoming week after an appropriately canceled lesson. Please work with your instructor to reschedule. Parents will be notified in advance if your instructor needs to cancel a lesson.

***Thank you for your interest in our therapeutic program! We look forward to partnering with you to improve the well being of our program participants.***

Please direct all completed forms, questions, or requests for more information to:

Jackie Griswold  
NARHA Instructor  
[jgriswold@dreamquesttr.com](mailto:jgriswold@dreamquesttr.com)

Suzanne Griswold  
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770-330-4295 ( Cell ) 404-487-2392 ( Fax )

404-723-5407 (Cell)

### REGISTRATION AND RELEASE FORM

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

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

Parent/Guardian: \_\_\_\_\_

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

Telephone: (Home) \_\_\_\_\_ (Business) \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email address: \_\_\_\_\_

In case of emergency: Contact \_\_\_\_\_ Phone: \_\_\_\_\_

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

School/Institution presently attending \_\_\_\_\_ :

Teacher's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

**LIABILITY RELEASE(REQUIRED):** \_\_\_\_\_ (name printed)  
would like to participate in Dream Quest E.F.P. Therapeutic Riding sessions. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/child/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 Dream Quest E.F.P. Therapeutic Riding , L. Kay Watson, Happy Mama Farm, Margaret and Richard Korges, Jackie Griswold, Suzanne Griswold, Aides, and Volunteers for any and all injuries and/or losses I/my child/my ward may sustain while participating in the Program.

Jackie Griswold, NARHA Instructor

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## AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury during the process or receiving services, or while on the property of the agency, I authorize Dream Quest E.F.P. and/or Dreamquest E.F.P. Therapeutic Riding to:

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

Student's Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Business) \_\_\_\_\_

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

If I cannot be reached please contact: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Business) \_\_\_\_\_

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

## CONSENT PLAN

This authorization includes x-rays, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person listed below cannot be reached.

DATE: \_\_\_\_\_ CONSENT SIGNATURE: \_\_\_\_\_  
(Client, parent, or guardian)

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

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**NON-CONSENT PLAN**

I do not give 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 the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place: \_\_\_\_\_

\_\_\_\_\_

DATE: \_\_\_\_\_ NON-CONSENT SIGNATURE: \_\_\_\_\_  
(Client, parent, or guardian)

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

***A COPY OF THE COMPLETED MEDICAL HISTORY (following) SHOULD BE ATTACHED TO THIS FORM***

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**Therapeutic Riding**

**MEDICAL HISTORY/RELEASE**  
*(Physician's Signature)*

STUDENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

DISABILITY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

NAME OF PARENT/GUARDIAN: \_\_\_\_\_

TELEPHONE(S) \_\_\_\_\_

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

DIAGNOSIS: \_\_\_\_\_ DATE OF ONSET: \_\_\_\_\_

**FOR PERSONS WITH DOWN'S SYNDROME:**

Cervical x-ray for Atlanto-axial instability: \_\_\_positive \_\_\_negative

Date of x-ray: \_\_\_\_\_ Comments: \_\_\_\_\_

Tetanus immunization: \_\_\_yes \_\_\_no Date of injection: \_\_\_\_\_

Seizure type: \_\_\_\_\_ controlled: \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_



PLEASE INDICATE IF PATIENT HAS A PROBLEM IN ANY OF THE FOLLOWING AREAS BY CHECKING YES OR NO.  
IF YES, PLEASE COMMENT, USING BACK OF PAPER IF NECESSARY.

AREA	YES	NO	Comments
<b>AUDITORY</b>			
<b>VISUAL</b>			
<b>SPEECH</b>			
<b>TACTILE</b>			
<b>CARDIAC</b>			
<b>CIRCULATORY</b>			
<b>PULMONARY</b>			
<b>NEUROLOGICAL</b>			
<b>VASCULAR</b>			
<b>VESTIBULAR/BALANCE</b>			
<b>ORTHOPEDIC</b>			
<b>ALLERGIES</b>			
<b>LEARNING DISABILITY</b>			
<b>MENTAL IMPAIRMENT</b>			
<b>SENSORY INTEGRATION DYSFUNCTION</b>			
<b>BEHAVIORAL</b>			



<b>PSYCHOLOGICAL</b>			
<b>SURGERY</b>			
<b>DEVELOPMENTAL DELAY</b>			
<b>OTHER</b>			

**MOBILITY:** Independent ambulation \_\_\_yes \_\_\_no crutches: \_\_\_yes \_\_\_no

Braces: \_\_\_yes :\_\_\_no Wheelchair: \_\_\_yes \_\_\_no

Please indicate any special precautions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PHYSICIAN SECTION**

In my opinion this patient can participate in supervised equestrian activities. In conjunction with these activities, I concur in the referral of the patient to a physical or occupational therapist for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program.

DATE: \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_

PHYSICIAN NAME: \_\_\_\_\_ (PRINT)

ADDRESS: \_\_\_\_\_

—

TELEPHONE(S): \_\_\_\_\_

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COMMENTS: _____ _____ _____
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**RELEASE FORM (Optional)**

Child's Name \_\_\_\_\_

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

**Kay Watson, Ed. S., L.P.C., N.C.C., Jackie Griswold, or Suzanne Griswold has my permission to both obtain and release verbal information about my child to the following people:**

Name \_\_\_\_\_ Position \_\_\_\_\_

Organization \_\_\_\_\_ Address \_\_\_\_\_

Phone number \_\_\_\_\_

Name \_\_\_\_\_ Position \_\_\_\_\_

Organization \_\_\_\_\_ Address \_\_\_\_\_

Phone number \_\_\_\_\_

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Signature

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Date

## **Rules For Dream Quest EFP Therapeutic Riding Students At Happy Mama Farm**

1. Follow directions of the adults in charge.
2. Always stay in the area around the barn.
3. Let an adult know if you have questions or concerns.
4. Give your best effort.
5. Be responsible for yourself and your horse.

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Signature of student

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Date

## **Rules For Dream Quest EFP Therapeutic Riding Parents At Happy Mama Farm**

1. Arrive for appointment time **NO EARLIER** than 15 minutes before session. Leave no later than 15 minutes after session.
2. When you open the gate, use the rope tie to hold it in place as you progress through the gate or have someone stand behind the gate and hold it.

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3. **CLOSE THE GATE!!** This is VERY important for the safety of all animals and people!
4. Travel at a very slow speed and park in the lot beside the barn.
5. No smoking.
6. No pets.
7. Parents will be able to watch sessions from a picnic bench near the arena or assist in the arena with the session. All clients, family members, volunteers and staff must stay in the area around the barn. There is a bathroom located in the tack room inside the barn.

\_\_\_\_\_  
Signature of parent

\_\_\_\_\_  
Date

### **PARTICIPANT PROFILE**

The therapeutic riding team will review the following information to develop an individualized therapeutic riding plan for the student.

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Please note any previous therapeutic or recreational riding experiences: \_\_\_\_\_

Health Challenge/Disability: \_\_\_\_\_

Posture (Head and trunk control): \_\_\_\_\_

Leg Abduction (Ability to spread legs apart on horse): \_\_\_\_\_

Balance/Movement/Coordination: \_\_\_\_\_

Behavior Attitude: \_\_\_\_\_

Perceptual Problems: \_\_\_\_\_

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Communication Problems: \_\_\_\_\_

Mental Ability: \_\_\_\_\_

Precautions and/or Restrictions for riding: \_\_\_\_\_

Suggestions: \_\_\_\_\_

Preferred times for lessons: \_\_\_\_\_

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
(Participant/Parent/Guardian)

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
(Staff/Instructor)

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