



**True Friends-True Strides**  
 10509 108<sup>th</sup> St. NW  
 Annandale, MN 55302  
 952-852-0101 - Fax 952-852-0123  
 Email: [info@truestrides.org](mailto:info@truestrides.org)  
 Website: [www.truefriends.org](http://www.truefriends.org)

**FOR OFFICE USE ONLY:** Application Rec'd. \_\_\_\_\_  
 Deposit Rec'd. \_\_\_\_\_  
 By \_\_\_\_\_  
 \_\_\_\_\_ WC SLW 1 2 3 4 5 6 7 8  
 P H SO Fb S D G O R C B RS H M L

**Application must be filled in completely.**

Please do not hesitate to include additional information which you feel may be helpful in the care of this individual. Thank you!

**Rider Personal Information:**

Name: \_\_\_\_\_  
 Last Legal First Name (Nickname ) Middle Initial

Address: \_\_\_\_\_  
 Street City State Zip

Telephone: \_\_\_\_\_

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

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male  Female  Weight: \_\_\_\_\_

**Contact Information:**

Check type of living situation: Residential Facility  Private Home  Other  Please list \_\_\_\_\_  
 If applicant lives outside of private home, what is the staff/client ratio? 1:1  1:2  1:3  1:4  1:5 or more

**Legal Guardian name**

Legal name: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_  
 Cell phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Guardian address: \_\_\_\_\_  
 Street City State Zip

**Social Worker name:**

Name: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_  
 Cell phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Guardian address: \_\_\_\_\_  
 Street City State Zip

Confirmation of service should be mailed to: (check one) parent  guardian  facility  participant  other: \_\_\_\_\_

Applicant Name:  Date of Birth:

**Contact Information Continued From Previous Page:**

**Emergency Contact Information #1:**

Legal name:  Relationship to applicant:   
Cell phone:  Home Phone:  Work:   
Email:   
Guardian address:   
Street City State Zip

**Emergency Contact Information #2:**

Legal name:  Relationship to applicant:   
Cell phone:  Home Phone:  Work:   
Email:   
Guardian address:   
Street City State Zip

**RELEASE SIGNATURES:**

**Attendance Release:** I hereby give my permission for the applicant named above, to participate in True Friends (TF) sponsored and supervised programs. **I certify that the information on the application is true, accurate and complete.** TF emphasizes safety first; however participation in TF programs has inherent risks that may result in injury. I acknowledge and accept this fact and agree to hold harmless TF, its employees, and agents.

**Emergency Release:** I hereby give permission to the non-medical staff selected by TF to provide routine health care, administer prescribed and comfort/first aid medications, and if needed, seek emergency medical treatment including x-rays, routine tests and treatment for applicant named above. **In the event that I cannot be reached in an emergency,** I hereby give permission to the physician selected by TF to secure and administer treatment including hospitalization, injections, anesthesia or surgery, for the applicant named above. I give permission to obtain copies of treatment and health records from any provider and I agree to release information and records necessary for treatment. TF cannot assume responsibility for any medical expenses that may occur if medical care must be sought.

**(REQUIRED)** Signature of parent, legal guardian, applicant if own guardian, or authorized person

Date signed

**We are unable to obtain signatures at this time. A copy** of this section has been sent to the appropriate individual for signatures and will be mailed to True Friends one month prior to applicant's arrival.

Applicant Name:  Date of Birth:

Name of Person Completing Application:  Date Application completed:

**DISABILITY/OTHER CONDITIONS: Check one:**  **with disability/other condition**  **without disability/other condition**  
*Please check all boxes that apply. Conditions in bold print \* require an additional questionnaire which our office will send you.*

Supervision or Support need is:  High  Medium  Low  Allergies to   
 Asperger Syndrome Reaction: Hives  Difficult breathing   
 Autism, type:  Anaphylaxis  Other

Attention Deficit Disorder or  Attention Deficit Hyperactivity Disorder  
 Alzheimer's or other Dementia (Beginning stages)  
 Blind/Vision impaired:  Wears glasses  Uses cane  
 Cerebral Palsy  
 Deaf/hearing impaired:  wears hearing aid(s)  
 Uses sign language (needs a staff proficient in sign language)  
 Developmental/Cognitive or Intellectual Disability  
 Down Syndrome  
 Oppositional Defiant Disorder  
 Pervasive Developmental Disorder  
 Prader-Willi Syndrome  
 Rett Syndrome  
 Tourette Syndrome  
 Traumatic Brain Injury  
 Williams Syndrome

Arthritis  
 Asthma  
 \*Catheter:  intermittent  in-dwelling  
 colostomy or ileo appliances  
 \*Diabetes,   
 insulin dependent  
 \*Feeding Tube:   
 \*Epilepsy/Seizures, type & frequency:

Further explanation for any condition or other disorder, explain:

\*Orthopedic appliances  
 splints  braces  prosthesis  
 \*Respiratory:  C-pap or  bi-pap  
 nebulizer  oxygen  suction  
 \*Tracheotomy  
 other   
 Heart problems, explain:

**Special Appliances/Ambulation – PLEASE PROVIDE NEEDED EQUIPMENT**

Wheelchair?  Yes  No  long distances only  Manual  Electric  Stroller  
Slow Walker?  Yes  No  
Assistance in walking?  Yes  No  support from another person  cane  walker  crutches  
Assistance in transferring?  Yes  No  
What type of transfer is used?  Mechanical Lift Only:  Yes  No  
Require **range of motion** exercises?  Yes  No If yes, please attach a copy of exercises.  
Does applicant wear/use?  Orthotics-----  left  right  Prosthesis-----  left  right  Braces/night braces  
Further Instructions:

**Bathroom Use**

Assistance in bathroom?  Independent  Needs reminders  Needs assistance  Total assistance  
Use of incontinent product?  Yes  No  
Further Instructions:

**Communication**

Able to communicate wants/needs?  Yes  No  
 Verbal  Uses a communication device  Sign Language  Non-verbally/gestures  
Type of communication devise:   
Understand/respond to questions?  Yes  No Needs extra time to process information  Yes  No  
Has difficulty understanding the communication of others  Yes  No  
Has difficulty expressing thoughts  Yes  No  
Able to read?  Yes  No Able to write?  Yes  No Can individual communicate pain?  Yes  No  
Further Instructions:

Applicant Name:  Date of Birth:

**Challenging Behavior - Check that apply:** (provide as much information as possible – use another paper as needed)

- Verbally challenging  Temper tantrums  Stubbornness  Wanders unintentionally due to distractions  
 Withdrawn/shy  Physically challenging toward objects  
 Displays unusual behaviors toward male staff  Displays unusual behaviors toward female staff

Other, describe:

Ever been away from home before?  Yes  No

Do you anticipate any concerns with this applicant going into the community  Yes  No

If yes please explain (refusing to wear a seat belt, difficulties riding in a vehicle, difficulty waiting, wandering, inappropriate interaction with strangers, etc):

If any of the following apply you are required to explain prevention/intervention:

- Self-injurious\***  **Lies / Steals\***  **Removes clothing at inappropriate times or locations**  
 **Physically challenging toward others\***  **Wanders or runs away intentionally\***  **Bites\***  
 **Swears\***  **Has fears\***  
 **Food-related behaviors\*** (stealing, temper tantrums, eating inedible objects, manipulation)

**Does this applicant ever require physical intervention?**  Yes  No

Please explain what type of physical intervention is used, for what purpose and how frequently this type of intervention is used:

**If there is any physical intervention that is contraindicated medically?**  Yes  No

Explain:

**Prior True Friends Experience:**

Has the applicant ever attended True Friends services?  Yes  No  No, but I'd like more information about:

- Respite  Summer Resident/Day Camp  Winter Resident Camp  Adventure Trip  Weekend Focus

Check site(s) attended:

- Camp Friendship  Camp Eden Wood  Camp New Hope  Camp Courage  Courage North

How did you hear about True Strides?

- social worker  teacher  friend/family  Arc  DSAM  AUSM  other support organization:

internet search/which site:

Attends school?  Yes  No

Where:  Type of Class:

Employed?  Yes  No Where:

What do they do at their job?

Please list any additional information regarding applicant, which may be helpful to staff (likes/dislikes):

Applicant Name:  Date of Birth:

**Fee Agreement (4 lessons are \$720) Hippotherapy  
Fee Agreement (4 lessons \$320) Therapeutic Riding**

I / We will pay cost of \$

Fee will be paid by:   
Amount                      Name of Payee                      address                      city                      state                      zip

I will contribute \$  to the "Donor Fund" to help another person attend a True Friends program.

**Method of Payment**

Cash

Check (Check# )

**Photos and Funds**

**Publicity Release:** True Friends uses photographs, images or recordings of applicants for publication in brochures, email, website and various other media to promote services or to recruit volunteers and staff. The applicant named above **MAY be included** in these promotional materials unless you contact Registration.

**Seeking Funds:** True Friends uses riders name to seek funds from donors for Financial Assistance. This applicant's first name and last initial **WILL be included** in seeking funds unless you contact Registration.

I/We verify that the information on this application is true and accurate.

Signature of rider/guardian

Date



## Liability Release

I, , (herein called Releaser), in consideration of being permitted to use the facilities and services of True Friends/Strides for himself/herself, spouse, my minor child, legal representatives, heirs and assigns, HEREBY RELEASES, TRUE FRIENDS/STRIDES, (HEREIN CALLED RELEASEE) THEIR OFFICERS, MEMBERS, AGENTS, EMPLOYEES AND VOLUNTEERS, FROM ALL LIABILITY TO THE RELEASOR, THEIR SPOUSE, LEGAL REPRESENTATIVES, HEIRS AND ASSIGNS, FOR ANY AND ALL LOSS OR DAMAGE, AND ANY CLAIM OR DAMAGES RESULTING THERE FROM ON ACCOUNT OF INJURY TO RELEASOR'S PERSON, EVEN INJURY RESULTING IN DEATH OF THE RELEASOR, WHETHER CAUSED BY THE NEGLIGENCE OF RELEASOR OR OTHERWISE WHILE THE RELEASOR IS RIDING, WORKING, OR FOR ANY PURPOSE USING THE FACILITIES, EQUIPMENT OR SERVICES OF TRUE FRIENDS/STRIDES.

- 1) I agree to indemnify TRUE FRIENDS/STRIDES and their officers, members, agents, employees or volunteers from any loss, damage or cost that may incur due to the participation or use of the facilities, equipment and services of Releasee due to the presence of myself or my minor child in or upon the property owned, Located at or controlled by TRUE FRIENDS/STRIDES whether caused by the negligence of the Releasees or otherwise.
- 2) I fully understand any involvement with horses involves some risk of harm or injury to myself, my minor child, my horses or my other property and that risk of damage or injury is a normal incident of involvement with horse-related activities and I hereby agree that risk is borne by me and/or my minor child and not by TRUE FRIENDS/STRIDES or their officers, members, agents, employees or volunteers.

**\*\* PLEASE CHOOSE ONE \*\***

**Consent Plan**

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) below is unable to be reached.

**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 the agency. In the event emergency treatment/aid is required, ***I wish the following procedures to take place:***

THIS RELEASE CONTAINS THE ENTIRE AGREEMENT BETWEEN THE PARTIES HERETO AND THE TERMS OF THIS RELEASE ARE CONTRACTUAL AND NOT A MERE RECITAL.  
I HAVE CAREFULLY READ THE FOREGOING RELEASE AND KNOW THE CONTENTS THEREOF **AND SIGNED THIS RELEASE AS MY OWN FREE ACT.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**(if under 18) Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



True Strides  
 10509 108<sup>th</sup> Street NW  
 Annandale, MN 55302  
 registration@truefriends.org  
 www.truestrides.org

**SEND TO PHYSICIAN**

## Contraindications to Equine Activities

Date:

Dear Health Care Provider,

Your patient, \_\_\_\_\_ (*participant's name*) is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present and to what degree. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/email indicated above.

Sincerely,

Director of True Strides

Orthopedic	NO	YES	COMMENTS
Atlantoaxial Instability - include neurologic symptoms	<input type="checkbox"/>	<input type="checkbox"/>	
Coxa Arthrosis	<input type="checkbox"/>	<input type="checkbox"/>	
Cranial Deficits	<input type="checkbox"/>	<input type="checkbox"/>	
Heterotopic Ossification/Myositis Ossificans	<input type="checkbox"/>	<input type="checkbox"/>	
Joint subluxation/dislocation	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Pathologic Fractures	<input type="checkbox"/>	<input type="checkbox"/>	
Spinal Joint Fusion/Fixation	<input type="checkbox"/>	<input type="checkbox"/>	
Spinal Joint Instability/Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Neurologic</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydrocephalus/Shunt	<input type="checkbox"/>	<input type="checkbox"/>	
Seizure	<input type="checkbox"/>	<input type="checkbox"/>	
Spina Bifida/Chiari II malformation	<input type="checkbox"/>	<input type="checkbox"/>	
Tethered Cord/Hydromyelia	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Medical/Psychological</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Animal Abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac Condition	<input type="checkbox"/>	<input type="checkbox"/>	
Physical/Sexual/Emotional Abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Pressure Control	<input type="checkbox"/>	<input type="checkbox"/>	
Dangerous to self or others	<input type="checkbox"/>	<input type="checkbox"/>	
Exacerbations of medical conditions (i.e. RA, MS)	<input type="checkbox"/>	<input type="checkbox"/>	

	No	Yes	COMMENTS
Fire Settings	<input type="checkbox"/>	<input type="checkbox"/>	
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	
Medical Instability	<input type="checkbox"/>	<input type="checkbox"/>	
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	
PVD	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory Compromise	<input type="checkbox"/>	<input type="checkbox"/>	
Recent Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Thought Control Disorders	<input type="checkbox"/>	<input type="checkbox"/>	
Weight Control Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Other</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Age - under 4 years	<input type="checkbox"/>	<input type="checkbox"/>	
Indwelling Catheters/Medical Equipment	<input type="checkbox"/>	<input type="checkbox"/>	
Medications - i.e. photosensitivity	<input type="checkbox"/>	<input type="checkbox"/>	
Poor Endurance	<input type="checkbox"/>	<input type="checkbox"/>	
Skin Breakdown	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	

**Please provide your professional opinion as to whether or not your patient is a suitable candidate for mounted horseback riding activities:**

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Physician's Signature

Date

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Physician's Printed Name

Thank you for your assistance.

**Please send materials at least three (3) weeks prior to camp to:**

**True Strides**

10509 108<sup>th</sup> Street NW

Annandale, MN 55302

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