TRUE FRIENDS
Camps. Respite. Programs. Travel.

Dear Camper and Horse Program Participant,

Welcome to True Strides! We are looking forward to a great summer with you as a participant in one of our horse sessions. Our program is directed by Shari Mangas, OTR and Path Certified Instructor. In addition to Shari we have highly trained staff experienced in working with horses, children and adults with special needs. Our team knows how to make it fun and safe at the same time. We will be following the Path International guidelines for safety standards to ensure all participants have a fulfilling, safe experience.

In order for a rider to participate in any of the programs they must:

1. Wear long pants and closed toed shoes;
2. Wear a helmet while on a horse. A helmet is provided;

Please Note: weight and ability to sit balance can be a prohibiting factor. It will be up to the discretion of the instructor as to the participant's qualifications to ride. We do back ride with individuals, however safety, behaviors and weight can be prohibitive to back riding.

Individuals who do not meet these policies are still encouraged to participate in all of the non-mounted horse activities, including grooming, paintings and learning about the horse.

Paperwork Requirements
To ensure that each participant can benefit from Mounted Riding Activities all paperwork found in the application packet for True Strides is required. All paperwork must be fully completed and returned at least three (3) weeks prior to attending the first session. Guardians, it is your responsibility to see that the physicians form is signed and returned.

The Liability Form must be returned or the participant will be unable to ride.

Thank you for entrusting us with your camper. We assure you this experience will be safe, fun and memorable. We look forward to seeing you this summer!

In Friendship,

The True Strides Team

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Liability Release

I, _____, (hearin 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, REPRESENTATIVES, HEIRS AND ASSIGNS, FOR ANY AND ALL LOSS OR DAMAGE, AND ANY CLAIM OF 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 108th 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	☐	☐	
Coxa Arthrosis	☐	☐	
Cranial Deficits	☐	☐	
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 (i.e. RA, MS)	☐	☐	

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

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

_____

Physician's Signature **Date**

_____

Physician's Printed Name

Thank you for your assistance.

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

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Annandale, MN 55302
registration@truefriends.org
www.truestrides.org