**True Friends-True Strides**
10509 108th St. NW
Annandale, MN 55302
952-852-0101 - Fax 952-852-0123
Email: info@truestrides.org
Website: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 ____________________

Reaction: Hives ☐ Difficult breathing ☐

Anaphylaxis ☐Other ____________________

☐Asperger Syndrome

☐Autism, type:____________________________

☐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

☐Further explanation for any condition or other disorder, explain:

____________________

☐Arthritis

☐Asthma

☐***Catheter:** ☐intermittent ☐in-dwelling

☐colostomy or ileo appliances

☐***Diabetes**, ____________________

☐**insulin dependent**

☐***Feeding Tube:** ____________________

☐***Epilepsy/Seizures**, type & frequency:

____________________

☐***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: ______________

**Hippotherapy Fee Agreement** **Single Lesson: $195**
**Therapeutic Riding Fee Agreement** **Single Lesson: $95**

☐ 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

True Strides
8046 83rd St. NW
Maple Lake, MN 55358

# 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 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:**

**True Strides**
10509 108th Street NW
Annandale, MN 55302
registration@truefriends.org
www.truestrides.org