MAURY MAGIC RIDERS, INC.

P.O. BOX 560
COLUMBIA, TN 38402
931-380-1119
www.maurymagicriders.com
a United Way Agency

Dear Parents/Guardians:

Attached is the application you requested for the upcoming riding session. The dates for the upcoming sessions are posted on our website. Please check www.maurymagicriders.com for those updates.

Each riding session will be six weeks long and the student will be instructed one hour each week either at 5:30 or 6:30 p.m. All of our instructors and therapists are volunteers who provide these services outside of their work day. The cost of a six week session is $80.00, due the first day of lessons. This fee helps defray the cost of caring for the horses and the farm as well as maintaining and improving the riding area. Parents/guardians may offer 6 or more hours of volunteer time in lieu of payment. If this is your wish, please indicate this when returning the completed rider application forms. Most volunteer hours that are available are in helping with another rider during lesson time, farm maintenance and improvement activities or becoming involved with the program on an administrative level. If you wish to volunteer in the riding program itself, you must attend the volunteer orientation the week before the students start riding. We do ask that all parents participate in at least two fundraising activities that we carry out in addition to volunteer hours and fee.

Please complete all the forms and return them **together** to our P.O. Box address. Applications for the spring session should be submitted by March 15; Applications for the Summer Session are due by April 30; Applications for the Fall Session are due by August 1.

Thank you for your interest in our program. We look forward to meeting you and your child and assisting your child with equine therapeutic activities.

Sincerely,

Stephanie G. Crews
President,
MAURY MAGIC RIDERS, INC.

MAURY MAGIC RIDERS, INC.
P.O. BOX 560
COLUMBIA, TN 38401

All riding lessons are held at the Maury Magic Riders Facility, located at 1210 Lofton Road, in Columbia Tennessee.

From Hwy 31 turn north on Hwy 43 or Bear Creek Pike, turn right on Tom J. Hitch Blvd. Go 1 mile to 1st caution light, turn left onto Iron Bridge Road. Go 2 miles and take the 1st road to the right, this is Lofton Rd. Look for the white Maury Magic Riders sign on the right.

From Hwy 50 turn, onto Tom J. Hitch Blvd. between the BP station and Highland Church of Christ. Go to 2nd caution light and turn right onto Iron Bridge Road. Go 2 miles and take the 1st road to the right, this is Lofton Rd. Look for the white Maury Magic Riders sign on the right.

You may contact Stephanie Crews at 931-279-0758 or info@maurymagicriders.com for directions.

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PARTICIPANT'S APPLICATION AND HEALTH HISTORY

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight:_____ M F

Address: _____
City State zip

Phone: _____ Alternate Phone: _____

Email Address: _____

Employer/School: _____

Address: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____
Contact Numbers: _____
How did you hear about the program? _____

Please indicate current or past problems in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

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

_____

_____

_____

_____

Describe you abilities/difficulties in the following areas (include assistance required or equipment 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?)

_____

_____

_____

_____

Signature: _____ Date: _____
Client, Parent or Legal Guardian

PARTICIPANT QUESTIONAIRE

In order for us to best serve you/your child please check all that apply.

Physical:

- ☐ Hypertoina – increased muscle tone or rigidity
- ☐ Hypotonia – Decreased muscle tone
- ☐ Limited Range of Motion
- ☐ Compromised Motor Function
- ☐ Fatigue
- ☐ Flaccid Limb
- ☐ Joint Discomfort
- ☐ Balance Difficulties
- ☐ Delayed Righting Response
- ☐ Asymmetrical Posture or Alignment
- ☐ Skin Sensitivity/Breakdown
- ☐ Incontinence

Cognitive:

- ☐ Delayed Processing
- ☐ Anxiety
- ☐ Impaired Balance or Decreased Body Awareness
- ☐ Impaired Sense of Safety/Judgment
- ☐ Short Attention Span
- ☐ Impaired Memory
- ☐ Limited Problem Solving Capabilities
- ☐ Difficulty Sequencing or Organizing Tasks

Learning Disabilities:

- ☐ Attention Deficit (Hyperactivity) Disorder
- ☐ Dyslexia
- ☐ Impaired Speech
- ☐ Impulsivity
- ☐ Difficulty with Change or Transitions

Language:

- ☐ Limited Receptive Language
- ☐ Limited Expressive Language
- ☐ Non Verbal
- ☐ Sign Language

- ☐ Deaf
- ☐ Perseveration – fixating on a single subject that may not be relevant or appropriate to the situation

Sensory Processing:

- ☐ Sensitive to Touch – please list areas of the body _____
  _____
- ☐ Sensory Seeking Behaviors
- ☐ Self Stimulation Behaviors
- ☐ Pica

Visual:

- ☐ Limited visual field – Please describe _____
  _____
- ☐ Blindness – ☐ Right eye ☐ Left eye ☐ Both

Emotional/Behavioral:

- ☐ Physical aggression towards others
- ☐ Physical aggression towards animals
- ☐ Impulsivity
- ☐ Emotional Instability – easily upset
- ☐ Withdrawn
- ☐ Poor Social Skills
- ☐ Manipulative behaviors
- ☐ Frustration
- ☐ Low Self-esteem

Please describe your behavior modification methods, triggers for behaviors, and rewards/consequences.

_____
_____
_____
_____
_____
_____
_____
_____

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PHOTO RELEASE
For promotional, marketing and social media.

Participant Name _____

Please check your choice for each

I ( ) Do
( ) Do Not
Consent to and authorize the use and reproduction by Maury Magic Riders, Inc. of any and all photographs and any other audio/visual material taken of me/my child for promotional material, educational activities, exhibitions or for any other use for the benefit of the program (does not include Social Media).

I ( ) Do
( ) Do Not
Consent to and authorize the use and reproduction by Maury Magic Riders, Inc. of any and all photographs and any other audio/visual material taken of me/my child for the Maury Magic Riders Facebook page and other social media outlets.

Signature:_____ Date:_____
Client, Parent or Legal Guardian

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PARTICIPANT'S LIABILITY RELEASE

_____ (Participant's Name) would like to participate in the Maury Magic Riders program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/my son/ my daughter/ my ward are greater than the risk assumed. I hereby, intend to legally bind myself, my heirs, and assigns, executors or administrator, and waive and release forever all claims for damages against Maury Magic Riders, its Board of Directors, Agents, Successors, Assigns, Instructors, Therapists, Aides, Volunteers and/or Employees including but not limited to the owners and lessors of any property at which the Program takes place for any and all injuries and or losses I/ my son/ my daughter/ my ward may sustain while participating in Maury Magic Riders Programs.

Date_____ Signature_____
(Client, Parent, or Guardian)

8/00

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

( )Participant ( )Staff ( ) Volunteer

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Medical Facility: _____

Health Insurance Company: _____

Allergies to Medications: _____

Current Medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Maury Magic Riders 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.

CONSENT PLAN

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

Date: _____ Consent Signature: _____

Client, Volunteer, Parent or Legal Guardian
(signed in the presence of operating center staff)

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:

_____

_____

_____

Date: _____ Consent Signature: _____

Client, Volunteer, Parent or Legal Guardian
(signed in the presence of operating center staff)

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM

Fundraising Pledge Form

_____ Rider Name

Dear Parents,

Maury Magic Riders is headed by a small board of about 6 members. All of these members perform several different functions in the running of MMR, including daily care and maintenance of the property and horses, fundraising, management, instruction, and much more. All of these members are volunteers. We do this because we care about MMR and the participants that we serve. In order to continue to bring this service to you for the small fee that we charge, we have to have income from outside sources, fundraisers, grants, and personal donations, etc. Obtaining this income requires time and effort. We have in the past asked very little from the parents or guardians of our riders, but we need your help now to make 2015 the best year ever for Maury Magic Riders.

We will have several fundraising events throughout the year. We request that you participate in at least two events annually. You will be notified by email of these events as they arise.

We welcome new ideas for fundraising and would love to hear them.

Also, any parent interested in joining the board to help in the planning and management of MMR is welcome to attend one of our meetings. They are held at 5pm on the Second Monday of each month at the King's Daughters School.

I _____ will participate in fundraising activities for Maury Magic Riders, Inc.

SIGNATURE (parent or guardian)

MAURY MAGIC RIDERS, INC.
P.O. BOX 560
COLUMBIA, TN 38401

Date:_____

Dear Physician:

Your Patient, _____ is interested in participating in supervised equestrian activities.

In order to safely provide this service, Maury Magic Riders requests that you complete the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precaution and contraindication to therapeutic horseback riding. Therefore, when completing this form, please note whether theses conditions are present and to what degree.

ORTHOPEDIC
Atlantoaxial Instability-include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis
Joint Subluxation/Dislocation
Osteoporosis
Pathological Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

NEUROLOGIC
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyella

OTHERS
Age – under 14 years
Indwelling Catheters
Medication – i.e. photosensitivity
Skin Breakdown

MEDICAL/PSYCHOLOGICAL
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbation of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

Thank you very much for your assistance. If you have and questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact Maury Magic Riders at the address indicated above.

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PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Particpant: _____DOB: _____ Height: _____ Weight: _____
Address: _____
Diagnosis: _____ Date of Onset : _____
Past/Prospective Surgeries: _____
Medication: _____
Seizure Type: _____
Shunt Present: Y N Date of last revision: _____
Mobility: Independent Ambulation: Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices: _____
For Those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result: + --
Neurological Symptoms of AtlantoAxial Instability: _____

Please indicate current or past difficulties in the following system/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

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 weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name: _____ MD DO NP PA Other _____
Signature: _____ Date: _____
Address: _____
Phone: ( )_____ License/UPIN Number: _____