



May 1, 2024

Dear Riders and Family Members,

The Butte Special Riders (BSR) is looking forward to another awesome summer of riding! Since 1989, BSR has provided therapeutic horseback riding for children and youth with special needs. BSR's main goal is to facilitate personal growth and development of social and physical skills for children and youth with special needs through equine interactions.

Our program continues to be an Accredited Operating Center of the Professional Association of Therapeutic Horsemanship (PATH) International with Joani Kissock and Barb Gray, Certified PATH Instructors. The program takes place at Kissock Horse Center (1179 Beacon Road, Butte, MT 59701).

We will be riding two sessions this summer:

- **Session 1:** June 10th, June 17th, June 24th & July 1st
- **Session 2:** July 15th, July 22nd, July 29th & August 5th

Daily sessions start at: 9:00AM, 9:45AM, 10:30AM, & 11:15AM. We will have assigned times your child will ride after the participant forms are returned.

Please return the white forms as soon as possible *or call Barb Gray by Friday, May 28th, 2024*. This will ensure enrollment of your child and will allow us to set up the time your child will ride. The blue forms (to be completed by your healthcare provider) can be returned to us via mail or in-person on your child's first day of riding. Your healthcare provider may also mail forms to us directly.

Attached are the forms that must be completed before they can participate in our program. ***Please put your child's estimated height and weight on the blue form.*** Our weight limit for BSR students is 175 pounds. This is to ensure rider, volunteer, and horse safety. Please note that the blue form must be filled out by your healthcare provider. Students will not be able to ride without these forms completed.

Please return the completed forms to Barb Gray at: **1302 Evans Ave, Butte, Montana 59701**. Please call Barb if you have any questions at **(406) 490-1715**. She will contact you with times and dates your child will ride.

This year we are charging a one-time \$5.00 fee to cover the insurance cost. This can be paid on the first day. If you cannot afford the fee, we have scholarships available! Please just let us know if you will need a scholarship.

All our special horses (Minnie, Romeo, Jade, Dutch, Eddie, Stewie, Vinny and Ladybug) cannot wait to see their friends again this summer (and neither can we!).

Sincerely,

The Butte Special Riders



Rider Registration and Release Form Registration

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Parent / Guardian Name: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

School or institution presently attending: _____

Emergency Contact Name: _____ Phone: _____

Liability Release

_____(STUDENT NAME) would like to participate in the Butte Special Riders program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to me/my son/my daughter/my 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 Butte Special Riders, it's Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/ or losses I/my son/my daughter/my ward may sustain while participating in (Client, Butte Parent Special or Riders. Guardian)

Signature: _____ Date: _____

Photo Release

I hereby consent to and authorize the use and reproduction by Butte Special Riders of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Signature: _____ Date: _____

Photo Release Non-Consent

I do not consent to or authorize the use and reproduction of any photographs or audiovisual materials taken by Butte Special Riders. (Client, Parent or Guardian)

(LEAVE BLANK IF NOT APPLICABLE)

Signature: _____ Date: _____



Rider's Authorization for Emergency Medical Treatment Form

In the event emergency, medical aid/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 Butte Special 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.**

Student First Name: _____ Student Last Name: _____

Date of Birth: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

In the event that the emergency contact listed above cannot be reached, please contact:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Physician's Name: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Preferred Medical Facility: _____

Preferred Medical Address: _____

Health insurance: _____ Policy #: _____



CONSENT PLAN:

This authorization includes x-ray, surgery, hospitalization, medication and any treatment deemed "life-saving" by the physician. This provision will only be invoked if the emergency contact, parent, or guardian are unable to be reached.

Signature: _____ Date: _____
Rider, Parent, or Guardian

Print Name: _____ Date: _____
Rider, Parent, or Guardian

Address: _____ Phone: _____

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:

Signature: _____ Date: _____
Rider, Parent, or Guardian

Print Name: _____ Date: _____
Rider, Parent, or Guardian

Address: _____ Phone: _____



Butte Special Riders Release of All Claims

The undersigned rider/volunteer (and rider/volunteer's parents) hereby agrees to the following terms and conditions of leading or walking, mount/dismount with horses of Kissock Horse Center or through the Butte Special Riders:

1. Rider/volunteer will use the horse only as instructed by the riding instructor.
2. Rider/volunteer will take all steps possible to ensure the horse's safety as well as rider/volunteer's own safety.
3. Rider/volunteer assumes all risks associated with horses and agrees not to hold Kissock Horse Center or Butte Special Riders, their proprietors, staff, employees, or any other agents of Kissock Horse Center or Butte Special Riders whomsoever liable for any injuries sustained by rider/volunteer while engaged in horseback riding or other associated activities in, at, or near Kissock Horse Center or the Butte Special Riders.
4. Rider/volunteer hereby releases Kissock Horse Center and the Butte Special Riders, their proprietors, staff, employees, or any other agents of Kissock Horse Center or Butte Special Riders whomsoever of and from any and all liability resulting from horseback riding and horse-related activities.

Rider/volunteer warrants that rider/volunteer has read the above and understands its terms.

Signature: _____ **Date:** _____
(Rider or Volunteer)

PARENT OR GUARDIAN MUST SIGN THE RELEASE BELOW IF RIDER/VOLUNTEER IS UNDER 18 YEARS OF AGE.

I, the undersigned parent of rider/volunteer, hereby release Kissock Horse Center and the Butte Special Riders whomsoever, of and from any and all liability for injuries or damages to the rider/volunteer, rider/volunteer's parents or his heirs at law resulting from horseback riding and associated activities and further agree to indemnify and hold harmless Kissock Horse Center and Butte Special Riders whomsoever from any loss suffered by Kissock Horse Center and the Butte Special Riders, their proprietors, staff, employees or any other agents of Kissock Horse Center and the Butte Special Riders whomsoever, caused by my child while horseback riding or engaging in horse-related activities.

Signature: _____ **Date:** _____
(Parent / Guardian)

****Please return the completed forms to Barb Gray at: 1302 Evans Ave, Butte, Montana 59701.
Please call Barb if you have any questions at (406) 490-1715****



Rider Medical History & Physician's Statement

TO BE COMPLETED ANNUALLY

RIDER NAME: _____

DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PARENT / GUARDIAN NAME: _____

DIAGNOSIS: _____

DATE OF ONSET: _____

HEIGHT: _____ WEIGHT: _____

TETANUS SHOT: YES NO SEIZURES: YES NO

SEIZURE TYPE: _____

DATE OF LAST SEIZURE: _____

CONTROLLED: _____

****FOR PERSONS WITH DOWN SYNDROME****

NEGATIVE CERVICAL XRAY FOR ATLANTOAXIAL INSTABILITY: YES NO

X-RAY DATE: _____

NEGATIVE FOR CLINICAL SYMPTOMS OF ATLANTOAXIAL INSTABILITY: YES NO



CURRENT MEDICATIONS (LIST BELOW):

PLEASE INDICATE IF PATIENT HAS A PROBLEM AND/OR SURGERIES IN ANY OF THE FOLLOW AREAS BY CHECKING YES OR NO . IF YES, PLEASE COMMENT.

AUDITORY YES NO

VISUAL YES NO

SPEECH YES NO

CARDIAC YES NO

CIRCULATORY YES NO

PULMONARY YES NO

NEUROLOGIC YES NO

MUSCULAR YES NO

COMMENT:



COMMENT:

ORTHOPEDIC YES NO

ALLERGIES YES NO

LEARNING DISABILITY YES NO

MENTAL IMPAIRMENT YES NO

PSYCHOLOGICAL IMPAIRMENT YES NO

INDEPENDENT AMBULATION YES NO

CRUTCHES, BRACES, OR WHEELCHAIR YES NO

SPECIAL PRECAUTIONS YES NO

Large empty rectangular area for providing comments.

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/CREDENTIALLED HEALTH PROFESSIONAL (I.E. PT, OT, SPEECH, PSYCHOLOGIST, ETC.) IN IMPLEMENTING OF AN EFFECTIVE EQUESTRIAN PROGRAM.

PHYSICIAN NAME (PLEASE PRINT): _____ PHYSICIAN SIGNATURE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: () _____ DATE: _____