

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: Stat	e: Zip Code:
Home Phone:	Work Phone:
Parent / Guardian Name:	
Address:	Address 2:
City: Stat	e: Zip Code:
Phone:	Email:
School or institution presently attending:	
Emergency Contact Name:	Phone:
Riders program. I acknowledge the risks the possible benefits to me/my son/my of intending to be legally bound, for mysel release forever all claims for damages Therapists, Aides, Volunteers and/or Em	STUDENT NAME) would like to participate in the Butte Special and potential for risks of horseback riding. However, I feel that daughter/my ward are greater than the risk assumed. I hereby, f, my heirs and assigns, executors or administrators, waive and against Butte Special Riders, it's Board of Directors, Instructors, nployees for any and all injuries and/ or losses I/my son/my ticipating in (Client, Butte Parent Special or Riders. Guardian)
Signature:	Date:
photographs and any other audiovisua	Photo Release use and reproduction by Butte Special Riders of any and all al materials taken of me/my son/my daughter/my ward for al activities or for any other use for the benefit of the program.
Signature:	Date:
	o to Release Non-Consent nd reproduction of any photographs or audiovisual materials rent 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 conto	act 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: Pho	ne:						
NON-CONSENT PLAN:							
I do not give my consent for emergency medical treatment/ai during the process of receiving services or while being on the p event emergency treatment/aid is required, I wish the following	property of the agency. In the						
Signature:	Date:						
Rider, Parent, or Guardian							
Print Name:	Date:						
Rider, Parent, or Guardian							
Address: Pho	ne:						





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: _

(Rider or Volunteer)

Date: _

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)

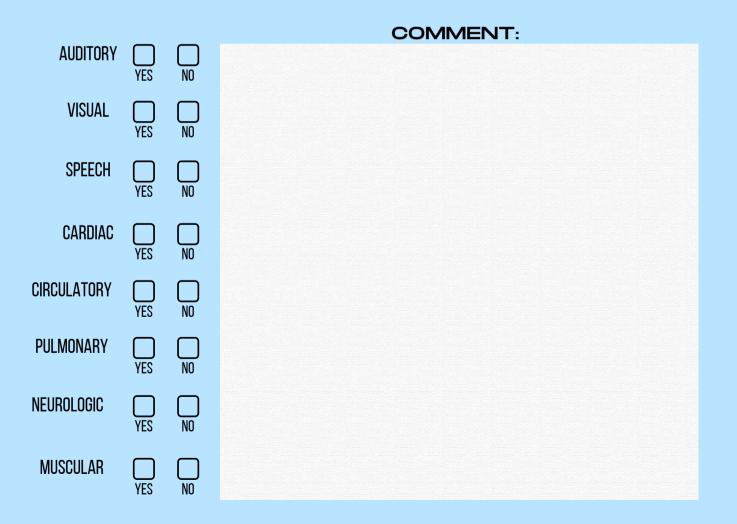
Please return the completed forms to Barb Gray at: 1302 Evans Ave, Butte, Montana 59701. Please call Barb if you have any questions at (406) 490-1715

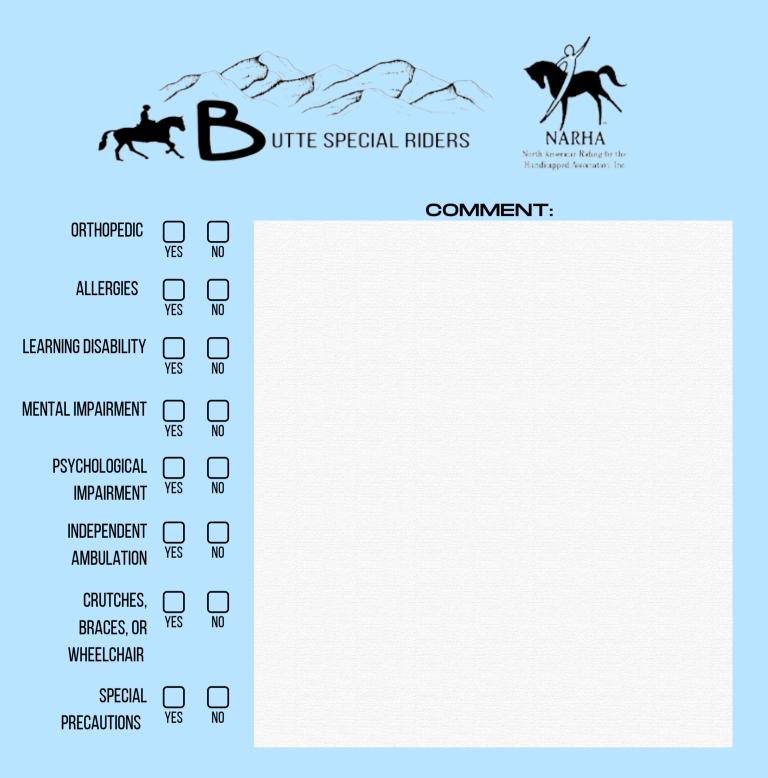
NARHA							
UTTE SPECIAL RIDERS NARHA North American Roding for the Handicapped Association. Inc.							
Rider Medical History & Physician's Statement							
TO BE COMPLETED ANNUALLY							
DOB:							
ADDRESS:							
CITY: STATE: ZIP:							
PARENT / GUARDIAN NAME:							
DIAGNOSIS:							
DATE OF 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 FORATLANTOAXIAL 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.





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

PHYSICIAN NA	ME (PLEASE PRINT):	PHYSIC			
ADDRESS:		CITY:	STATE:	ZIP:	
PHONE: (]	DATE:			