Vinceremos Therapeutic Riding Center

Letter to Parents

Dear Parents, Caretakers and Clients:

It is time to prepare for the 2018/2019 season at Vinceremos. We appreciate the opportunity to serve you and enjoy seeing the positive impact that adding horses and horse sports to your rider's life can provide. Our commitment to maintaining the highest quality of care for our riders defines the Vinceremos experience. Small classes and instructors with the best credentials means that these standards are preserved. In order to meet our obligations this year we need you to meet yours too!

Please find enclosed the full Registration Packet which MUST be filled out in its entirety and returned to the administration office to guarantee your spot in the schedule.

It is very important that the entire registration packet be returned by August 15th with the following items complete: MAKE YOUR DOCTOR'S APPOINTMENT TODAY!

- **All Release Forms Signed**
- **All Physician Forms and Signature lines signed.**
- **Complete your Financial Aid Request, including the letter to be submitted to the Scholarship Committee.**
- The Special Olympic Medical Form is enclosed for your convenience; if your rider qualifies and intends to attend, please fill this out.

To request a specific day and /or time for your lesson, please be sure that you make this request as soon as possible. We will do our best to accommodate you, but we make no promises. **All riders are required to make their payment prior to riding on the 1st day of each session, *no exceptions***. You can make your payment via phone, mail or in person. Participants requesting Financial Aid should submit the additional information required (please see the Financial Aid Request attached).

Please be sure to become familiar with all of the information provided in this packet: Weather Policy, Attendance Policy, Financial Aid, Volunteering Opportunities and the Pricing information.

Thank you for your help and cooperation. We look forward to a successful year!

All the best,

Ruth Menor
Founder and Program Director

13300 Sixth Court North, Loxahatchee, FL 33470 Phone: (561) 792-9900 Fax: (561) 795-1774
www.vinceremos.org www.facebook.com/vinceremosTRC/

Vinceremos Therapeutic Riding Center

Program Tuition

Vinceremos is committed to providing Equine Assisted Activities and Therapies to individuals and groups who benefit from these specialized services. As of June 1, 2018, the actual cost per service unit was $160. Vinceremos provides a sliding scale of tuition by subsidizing this cost through the generosity of individual donors, corporate sponsors, grants and fundraising activities. The tuition that participants are asked to pay is established annually. As of August 1, 2018, that fee is $60 per Therapeutic Riding lesson; 37.5% of the actual cost. A schedule of fees is listed below. Additional Financial Assistance may be awarded through the Financial Aid application and review process. Awards are based on availability of funds and financial need. (Financial Aid Request form is included in this packet.)

2018-2910 Pricing for Reference:

Pricing per lesson	Therapeutic Riding	Equine Assisted Learning	Hippotherapy with Physical Therapy	Equine Facilitated Psychotherapy
Private	$60	$75	$70	$125
Semi-Private	$55	$60	n/a	$100
Group (3-5)	$50	$35	n/a	$75
Group (6-10)	n/a	$25	n/a	n/a

Additional activity fees include:

Holiday Horse Show	-		$25
Special Olympics Event	-	County Games	$30
	-	Area Games	$30
	-	State Games	$50

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Application Process

Applications are available in the Administrative Offices at the farm or by e-mail by calling the office at (561) 792-9900. The following forms are mandatory prior to participation:

- **Rider Participation Forms**
- **Physician's Statement for Participation**

Each form must be signed by the appropriate party.
The Physician's Statement **MUST** be signed and dated by a physician.
When **ALL** forms have been received, **NEW** riders will be contacted for an assessment that will be conducted by our staff. Following the Assessment, the rider will be placed in an appropriate lesson.

Scheduling: Vinceremos sessions run concurrently with the school year and consist of three (3) 11-week sessions. The 9-week Summer session is offered in addition and by arrangement. Usually, therapeutic riders with similar goals are grouped together. Lessons are scheduled for the same day and time for the entire session. Vinceremos operates Monday through Saturday during the school year and Monday through Friday during the Summer session. Participants will be notified of their ride times 3 weeks ahead of the start of the Fall session.

Attendance: Riders must be prepared to begin their class 10 minutes ahead of their scheduled start time. Late riders will join the lesson at the discretion of the instructor. If you arrive 15 minutes late for your lesson, you will not be able to join the class. Please call the office if you are going to be late or if you are unable to attend your lesson.

Riders who miss 2 consecutive lessons without notifying the office may be removed from the schedule.

Rider's Responsibility:

- Arrival Time: Riders must arrive 10 minutes in advance of their lesson and be prepared.
- Cancellation: Please notify the office if you are cancelling your lesson, preferably the day before (minimum of 1 hour in advance) at **561-792-9900** or info@vinceremos.org.
- Attire: All Participants should wear closed-toe shoes and rider's shoes should have a prominent heel. Long pants should be worn. Helmets are available for use at the farm, or you may choose to purchase your own.

Payment: Lessons are prepaid in advance of each session. The tuition is due on the first day of class unless a pre-arranged payment plan or financial aid has been established by individual arrangement with our business office.

Financial Aid: Vinceremos is able to offer some financial aid depending on the amount of funds available in the form of adjusted fees to those who demonstrate need. Participants may apply by filling out the Financial Aid Application. Financial Aid Application forms are due no later than **August 7th** for the subsequent year. Riders will be notified of their awards as soon as possible.

Weather Policy: If there is lightning detected within 6 miles of the center, we will not ride until it is clear for 30 minutes. If the Weather Policy is in effect, we will conduct unmounted lessons. Even if the weather seems clear, we will utilize our lightning detector as an indicator for safety.

Rider Forms

Vinceremos Therapeutic Riding Center

Unveiling Hidden Potential

CLIENT INFORMATION

Client Name: _____

☐ Male ☐ Female Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone: _____ Cell Ph: _____

School/Institution Attending: _____

How did you hear about Vinceremos? _____

Parent/Guardian Information:

Parents/Guardians: _____

☐ Please check if information is same as above.

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone: _____ Cell Ph: _____

Client's Personality Profile:

Learning Style: ☐ Visual/learns by seeing ☐ Auditory/learns by hearing ☐ Kinesthetic/learns by doing

Please describe personality and strengths: _____

_____

What are some favorite activities or topics? _____

What are some fears or dislikes? _____

Psychological, emotional, behavioral, social issues: _____

_____

Successful Intervention Strategies Used (sensory modalities, behavioral, rewards, etc.): _____

_____

Our Family's Do's and Don'ts: _____

_____

Any other special information we should know? _____

Please list any goals (i.e., what would you like to accomplish in the therapeutic riding / hippotherapy? _____

_____

Office Use Only

New Client____ Existing Client____ Assessed By_____ Instructor_____

Rider Forms

Vinceremos Therapeutic Riding Center

Unveiling Hidden Potential

Vinceremos Therapeutic Riding Center

PATH INTERNATIONAL

Client Name: _____

Client's Medical Information:

Diagnosis - Primary/Secondary: _____ Height: _____ Weight: _____

Physician's Name: _____ Physician's Phone Number: _____

Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies and Treatment Required: _____

Current Medications: _____ Medical Bracelet? _____

Describe General Balance: _____

Please list and explain ANY assistive devices that the participant may use at home or school: _____

Any other special information we should know? _____

Client's Physical Skills:

Is the participant proficient in the following skills? Mark an X for yes.

_____ Release Objects	_____ Sits Unassisted	_____ Uses Right Hand Independently
_____ Bears Weight on Legs	_____ Stands Independently	_____ Uses Left Hand Independently
_____ Bears Weight on Hands	_____ Walks Unassisted	_____ Climbs Stairs
	_____ Runs Unassisted	_____ Uses Bathroom Independently

Describe General Balance: _____

Please list and explain ANY assistive devices that the participant may use at home or school: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Office Use Only

New Client____ Existing Client____ Assessed By_____ Instructor_____

Rider Forms
Vinceremos Therapeutic Riding Center
Unveiling Hidden Potential

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Client Name:_____

CONSENT PLAN: 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 Vinceremos Therapeutic Riding Center 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.

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

Date: _____ **Consent Signature:**_____
Rider (if 18 years of older), Parent or Legal Guardian

- or -

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.

1. Parent or legal guardian will remain on site at all times during equine assisted activities.
2. In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

Date: _____ **Non-Consent Signature:**_____
Rider (if 18 years of older), Parent or Legal Guardian

PHOTO RELEASE

☐ **I Do** ☐ **I Do Not** Consent to and authorize the use and reproduction by Vinceremos Therapeutic Riding Center of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions, or for any other use for the benefit of the Center.

Date: _____ **Signature**: _____
Rider (if 18 years or older), Parent or Legal Guardian

Office Use Only
New Client____ Existing Client____ Assessed By_____ Instructor_____

Rider Forms
Vinceremos Therapeutic Riding Center
Unveiling Hidden Potential

EQUINE ACTIVITY LIABILITY RELEASE, WAIVER OF RIGHT TO SUE, AND ASSUMPTION OF ALL RISKS

READ BEFORE SIGNING

This Equine Activity Liability Release, Waiver of Right to Sue and Assumption of All Risks Agreement (the "Agreement") is hereby given by _____ ☐ on his/her own behalf OR ☐ as the parent or guardian of _____ to VINCEREMOS RIDING CENTER, INC., a Florida not-for-profit corporation, as the equine activity sponsor (the "Sponsor"), and to each officer, director, agent, employee, volunteer, equine professional (as defined in the Act referenced herein), instructor, therapist, aide, heir, personal representative, successor and/or assign of the Sponsor (who also shall be included within the word "Sponsor") and agrees as follows:

In consideration of the opportunities provided by the Sponsor to the undersigned, including any minor or legal ward in whose behalf the undersigned signs this Agreement (collectively, the "Participant"), for the enjoyment of equine activities and the use of the Sponsor's facility and equipment, the Participant hereby agrees as follows:

1. This Agreement is given in part under the Florida Equine Activities statutes (Chapter 773) as it may now provide or be hereafter amended (the "Act"). All terms defined by the Act shall have the same meaning herein, and the Act is hereby incorporated in this Agreement by reference. This Agreement shall be so construed as to provide to the Sponsor the fullest protection of a release, waiver of claim and recovery, right to sue and assumption of all risks that is afforded by the Act, and by other applicable statutes and general law.

2. The Participant hereby acknowledges that he/she has full and complete notice and understanding of the Act and of all the dangers and/or conditions which are an integral part of equine activities which may cause, contribute to or result in the death or personal injury of the Participant or damage to the Participant's property (the "Risks"), including, but not limited to:

   The propensity of equines to behave in ways (such as, but not limited to, buck, stumble, fall, rear, bite, kick, run, and make unpredictable movements, spook, jump obstacles, step on a person's feet, push or shove a person, saddles or bridles may loosen or break) that may result in injury, harm, or death to persons on or around the equine;

   The unpredictability of an equine's reaction to sounds, sudden movement, persons, other animals, or unfamiliar objects;

   Hazards, including, but not limited to, surface or subsurface conditions;

   A collision with another equine, another animal, a person, or an object;

   The potential of an equine activity participant to act in a negligent manner that may contribute to injury, death, or loss to the person of the participant or to other persons, including, but not limited to, failing to maintain control over an equine or failing to act within the ability of the participant;

   The inability of anyone whomsoever to predict or foresee an equine's reaction to excitement, weather conditions, sound, movements, objects, vehicles, persons, animals, reptiles, birds or insects, and the effects of such reactions;

   The dangers and risks of tack or harness loosening, slipping or breaking for whatever reason.

   The dangers and risks of becoming entangled in tack, harness, or vehicles used in an equine activity;

   The risks of falling from or otherwise becoming unstable on an equine or a vehicle used in an equine activity for any reason whatsoever or for no identifiable reason;

   Any negligent act or omission by the Sponsor which causes or results in the death or personal injury of the Participant or damage to the Participant's property.

3. The Participant hereby expressly assumes all risks and dangers of injury, loss, damage or death which are in any way resulting from the inherent risks of equine activities and/or associated with the Risks enumerated in paragraph 2 above.

Initial:_____
Date:_____

4. The Participant hereby releases and waives all rights which he/she may have or hereafter have against the Sponsor for injury, loss, damage or death which is in any way resulting from the inherent dangers of equine activities and/or associated with the Risks enumerated in Paragraph 2 above, and the right to sue or to bring any action against the Sponsor in connection therewith. The Participant agrees to completely indemnify and hold the Sponsor harmless from and against any and all claims, demands, causes of action, suits, actions, losses, liabilities, costs and/or expenses, including medical costs and attorney's fees, which are occasioned by, or otherwise attributable to, matters for which the Participant has hereby assumed the risk and is responsible in accordance with this Agreement.

5. The Participant agrees to comply with all rules and regulations posted or otherwise communicated by the Sponsor. The Participant agrees that the Sponsor has made reasonable and prudent efforts to determine the Participant's ability to engage in the Equine Activity offered by the Sponsor and the Participant has disclosed all known physical and psychological conditions to Sponsor to assist Sponsor in evaluating the Participant for participation in the Equine Activity offered by the Sponsor.

6. The Participant agrees that mounting, riding, walking, dismounting, grooming, training, handling, feeding, and otherwise being in the physical proximity of horses is a dangerous activity which produces a foreseeable risk of mortal or serious personal injury and/or property loss to the Participant in such activity as well as to the person or property of others.

7. This Agreement shall remain valid and in full force and effect from and after the date opposite the signature of the Participant until expressly revoked by the Participant in a written notice personally delivered to the Sponsor.

8. This Agreement shall be construed under Florida law in such manner as will render it, and each provision of it, fully enforceable; provided, however, that if any provision of this Agreement shall be unenforceable, such provision (or so much thereof as is unenforceable) shall be deleted and the remainder of this Agreement shall continue in full force and effect. Venue for purposes of any litigation or arbitration concerning this Agreement shall be in Palm Beach County, Florida.

9. If this Agreement is executed by the undersigned for and on behalf of a minor Participant as named below, the undersigned hereby warrants and represents that he/she is in fact the legal parent or guardian of such minor, with full rights of custody and control; that this Agreement is given on behalf of and is intended to be binding upon said minor Participant, his/her heirs, personal representatives, successors and assigns; and the undersigned further agrees that this Agreement shall also be as fully binding on the undersigned as if it were entered into solely on his/her own behalf.

10. This Agreement shall be binding upon the heirs, personal representatives, successors and assigns of the Participant and the undersigned.

WARNING

Under Florida Law, an equine activity sponsor or equine professional is not liable for any injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.

I HAVE FULLY READ AND FULLY UNERSTAND THE FOREGOING EQUINE LIABILITY RELEASE, WAIVER OF RIGHT TO SUE AND ASSUMPTION OF ALL RISKS. I HAVE CONSULTED AND RELILED UPON MY OWN ADVISORS ON ALL QUESTIONS IN CONNECTION THEREWITH AND FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT. I HAVE NOT RELIED UPON THE SPONSOR FOR ANY ADVICE OR EXPLANATION IN CONNECTION THEREWITH.

Print Name: _____ Date: _____

Signature: _____

FOR MINORS UNDER 18 YEARS OF AGE:

Print Name of Minor: _____ Date: _____

Address: _____

Telephone Numbers: Cell (___) _____ Home (____) _____ Work (____) _____

Physician's Statement
Vinceremos Therapeutic Riding Center
Unveiling Hidden Potential

Dear Health Care Provider:

Your patient, _____ is interested in participating in supervised equine activities.
(Participant's Name)

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. Thank you very much for your assistance. 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/phone below.

Orthopedic
Atlantoaxial Instability - including neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint Subluxation/Dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

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)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Cord/ Hydromyelia

Other
Age - Under 4 years
Indwelling Catheters/Medical Equipment
Medications, i.e. Photosensitivity
Poor Endurance
Skin Breakdown

THIS SECTION MUST BE COMPLETED IN FULL

Past/Prospective Surgeries: _____

List Medications: _____

Seizure Type: _____ Controlled? Y N Date of Last Seizure: _____

Shunt Present? Y N Date of Last Revision: _____

Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N Braces/Assistive Devices? Y N

For those with Down Syndrome: AtlantoDens Interval X-Rays Date:_____ Result: + --

Neurologic Symptoms of AtlantoAxial Instability: _____

_____

Physician's Signature: _____ **Date:** _____

13300 Sixth Court North, Loxahatchee, FL 33470 Ph: (561) 792-9900 Fax (561) 795-1774 www.vinceremos.org

Physician's Statement

Vinceremos Therapeutic Riding Center

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THIS SECTION MUST BE COMPLETED IN FULL

Participant: _____ DOB: _____ Height: _____ Weight*: _____

Participant Address: _____ Participant Phone: _____

Special Precautions/Needs: _____

Diagnosis: _____ Date of Onset: _____

*VTRC horses are unable to carry riders over 200 lbs.

Please indicate current or past special needs in the following systems/areas, including surgeries:

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

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that PATH International will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to PATH International for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Physician's Signature: _____ **Date:** _____

Address: _____

Phone: ( ) _____ License/UPIN Number: _____

FINANCIAL AID

Applications for Financial Aid are made each year at the beginning of the Fall Session or during a Client's initial Assessment. All awards are made based on available funds and financial need. Awards may range from $100 - $500 per session. Applicants are required to fill out the Financial Aid Application enclosed and submit at least two (2) of the following documents:

FOR EMPLOYEED INDIVIDUALS:

1) ☐ Pay Stubs: 30 days of recent pay stubs from all employers for both parents.

2) ☐ W2 Forms: For the last tax year.

3) ☐ Social Security Award Letters or any other Financial Aid received.

FOR SELF-EMPLOYED INDIVIDUALS:

1) ☐ First page of your Federal Tax Return for the most recent year.

2) ☐ 1 Month of your most current bank statement.

Please black out Social Security Numbers and Bank Account Numbers.

In addition, please attach a brief letter to our Financial Aid Committee to explain how Equine Assisted Activities will benefit or has benefited your applicant.

Other financial resources you may apply to:

Hannaandfriends.org
BellasAngels.org

Vinceremos Therapeutic Riding Center
Financial Aid Request Form

Unveiling Hidden Potential

Rider Name: _____ Date: _____

Parent/Guardian Name/s: _____ Day Phone: _____

E-Mail: _____

School/Day Program: _____ Grade (circle) K 1 2 3 4 5 6 7 8 9 10 11 12

Other therapies the Rider is participating in: **Required*

_____

_____

_____

Financial Information

Family Size: _____ Number of Children: _____ Number of Children with Special Needs: _____

Ages of Children: _____

Total Gross Monthly Wages (your wage & spouse or other): $_____

Monthly Child Support: $_____ SSI: $_____ SSDI: _____

Parent/Guardian Marital Status ☐ Single ☐ Married ☐ Divorced

Occupations(s): _____

Considerations

Are there any special circumstances that need to be taken into consideration? (Ex. both parents in school) _____

_____

Reason for Requesting this Scholarship

Please answer this question in letter format addressed to the VTRC Board of Directors, Scholarship Committee and submit it with the Rider paperwork.

How do you feel your Rider will benefit from Therapeutic Riding?

_____

_____

_____

_____

_____

- Individual lesson rates, including Scholarship Awards, will range from $10 - $50.
- The Scholarship Committee reserves the right to make exceptions based on specific situations that demonstrate extreme need.

I certify that the above information is accurate and complete to the best of my knowledge.

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

For Office Use ONLY: Received By: _____ Date: _____ Reviewed: Y N

13300 Sixth Court North, Loxahatchee, FL 33470 Ph: (561) 792-9900 Fax (561) 795-1774 www.vinceremos.org

Athlete Medical Form – HEALTH HISTORY

(To be completed by the athlete or parent/guardian/caregiver and brought to exam)

Special Olympics

Athlete First & Last Name:_____ **Preferred Name:**_____

Athlete Date of Birth (mm/dd/yyyy):_____ ☐ Female ☐ Male

STATE PROGRAM:_____ **E-mail:**_____

ASSOCIATED CONDITIONS - Does the athlete have *(check any that apply)*:

☐ Autism ☐ Down Syndrome ☐ Fragile X Syndrome
☐ Cerebral Palsy ☐ Fetal Alcohol Syndrome
☐ Other Syndrome, please specify:_____

ALLERGIES & DIETARY RESTRICTIONS

☐ No Known Allergies
☐ Latex
☐ Medications:_____
☐ Insect Bites or Stings:_____
☐ Food:_____

ASSISTIVE DEVICES - Does the athlete use *(check any that apply)*:

☐ Brace ☐ Colostomy ☐ Communication Device
☐ C-PAP Machine ☐ Crutches or Walker ☐ Dentures
☐ Glasses or Contacts ☐ G-Tube or J-Tube ☐ Hearing Aid
☐ Implanted Device ☐ Inhaler ☐ Pacemaker
☐ Removable Prosthetics ☐ Splint ☐ Wheel Chair

List any special dietary needs:

SPORTS PARTICIPATION

List all Special Olympics sports the athlete wishes to play:

Has a doctor ever limited the athlete's participation in sports?
☐ No ☐ Yes *If yes, please describe:*

SURGERIES, INFECTIONS, VACCINES

List all past surgeries:

Does the athlete currently have any chronic or acute infection?
☐ No ☐ Yes *If yes, please describe:*

Has the athlete ever had an abnormal Electrocardiogram (EKG) or Echocardiogram (Echo)? *If yes, describe date and results*
☐ Yes, had abnormal EKG
☐ Yes, had abnormal Echo

Has the athlete had a Tetanus vaccine in the past 7 years? ☐ No ☐ Yes

EPILEPSY AND/OR SEIZURE HISTORY

Epilepsy or any type of seizure disorder ☐ No ☐ Yes

*If yes, list seizure type:*_____

If yes, had seizure during the past year? ☐ No ☐ Yes

MENTAL HEALTH

Self-injurious behavior during the past year	☐ No	☐ Yes	**Depression** *(diagnosed)*	☐ No	☐ Yes
Aggressive behavior during the past year	☐ No	☐ Yes	**Anxiety** *(diagnosed)*	☐ No	☐ Yes

Describe any additional mental health concerns:

FAMILY HISTORY

Has any relative died of a heart problem before age 50? ☐ No ☐ Yes

Has any family member or relative died while exercising? ☐ No ☐ Yes

List all medical conditions that run in the athlete's family:

Athlete Medical Form – **HEALTH HISTORY**

(To be completed by the athlete or parent/guardian/caregiver and brought to Exam)

Athlete's First and Last Name:_____

HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS

Loss of Consciousness	☐ No ☐ Yes	High Blood Pressure	☐ No ☐ Yes	Stroke/TIA	☐ No ☐ Yes
Dizziness during or after exercise	☐ No ☐ Yes	High Cholesterol	☐ No ☐ Yes	Concussions	☐ No ☐ Yes
Headache during or after exercise	☐ No ☐ Yes	Vision Impairment	☐ No ☐ Yes	Asthma	☐ No ☐ Yes
Chest pain during or after exercise	☐ No ☐ Yes	Hearing Impairment	☐ No ☐ Yes	Diabetes	☐ No ☐ Yes
Shortness of breath during or after exercise	☐ No ☐ Yes	Enlarged Spleen	☐ No ☐ Yes	Hepatitis	☐ No ☐ Yes
Irregular, racing or skipped heart beats	☐ No ☐ Yes	Single Kidney	☐ No ☐ Yes	Urinary Discomfort	☐ No ☐ Yes
Congenital Heart Defect	☐ No ☐ Yes	Osteoporosis	☐ No ☐ Yes	Spina Bifida	☐ No ☐ Yes
Heart Attack	☐ No ☐ Yes	Osteopenia	☐ No ☐ Yes	Arthritis	☐ No ☐ Yes
Cardiomyopathy	☐ No ☐ Yes	Sickle Cell Disease	☐ No ☐ Yes	Heat Illness	☐ No ☐ Yes
Heart Valve Disease	☐ No ☐ Yes	Sickle Cell Trait	☐ No ☐ Yes	Broken Bones	☐ No ☐ Yes
Heart Murmur	☐ No ☐ Yes	Easy Bleeding	☐ No ☐ Yes	Dislocated Joints	☐ No ☐ Yes
Endocarditis	☐ No ☐ Yes	**If female athlete, list date of last menstrual period:**_____			

Describe any past broken bones or dislocated joints *(if yes is checked for either of those fields above)*:

List any other ongoing or past medical conditions:

Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability

Difficulty controlling bowels or bladder	☐ No ☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No ☐ Yes
Numbness or tingling in legs, arms, hands or feet	☐ No ☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No ☐ Yes
Weakness in legs, arms, hands or feet	☐ No ☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No ☐ Yes
Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet	☐ No ☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No ☐ Yes
Head Tilt	☐ No ☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No ☐ Yes
Spasticity	☐ No ☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No ☐ Yes
Paralysis	☐ No ☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No ☐ Yes

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW

(includes inhalers, birth control or hormone therapy)

Medication, Vitamin or Supplement Name	*Dosage*	*Times per Day*	*Medication, Vitamin or Supplement Name*	*Dosage*	*Times per Day*	*Medication, Vitamin or Supplement Name*	*Dosage*	*Times per Day*

Is the athlete able to administer his or her own medications? ☐ No ☐ Yes

Name of Person Completing this Form	**Relationship to Athlete**	**Phone**	**Email**

Athlete Medical Form – **PHYSICAL EXAM**

(To be completed by a Licensed Medical Professional qualified to conduct exams & prescribe medications)

Athlete's First and Last Name: _____

MEDICAL PHYSICAL INFORMATION

(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

Height	Weight	BMI *(optional)*	Temperature	Pulse	O_2Sat	Blood Pressure (in mmHg)		Vision
cm	kg	BMI	C			BP Right:	BP Left:	Right Vision 20/40 or better ☐ No ☐ Yes ☐ N/A
in	lbs	Body Fat %	F					Left Vision 20/40 or better ☐ No ☐ Yes ☐ N/A

Right Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate	
Left Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate	
Right Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body	
Left Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body	
Right Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA
Left Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA
Oral Hygiene	☐ Good	☐ Fair	☐ Poor	
Thyroid Enlargement	☐ No	☐ Yes		
Lymph Node Enlargement	☐ No	☐ Yes		
Heart Murmur (supine)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater	
Heart Murmur (upright)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater	
Heart Rhythm	☐ Regular	☐ Irregular		
Lungs	☐ Clear	☐ Not clear		
Right Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+ ☐ 4+	
Left Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+ ☐ 4+	
Radial Pulse Symmetry	☐ Yes	☐ R>L	☐ L>R	
Cyanosis	☐ No	☐ Yes, describe		
Clubbing	☐ No	☐ Yes, describe		

Bowel Sounds	☐ Yes	☐ No			
Hepatomegaly	☐ No	☐ Yes			
Splenomegaly	☐ No	☐ Yes			
Abdominal Tenderness	☐ No	☐ RUQ	☐ RLQ	☐ LUQ	☐ LLQ
Kidney Tenderness	☐ No	☐ Right	☐ Left		
Right upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Left upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Right lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Left lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Abnormal Gait	☐ No	☐ Yes, describe below			
Spasticity	☐ No	☐ Yes, describe below			
Tremor	☐ No	☐ Yes, describe below			
Neck & Back Mobility	☐ Full	☐ Not full, describe below			
Upper Extremity Mobility	☐ Full	☐ Not full, describe below			
Lower Extremity Mobility	☐ Full	☐ Not full, describe below			
Upper Extremity Strength	☐ Full	☐ Not full, describe below			
Lower Extremity Strength	☐ Full	☐ Not full, describe below			
Loss of Sensitivity	☐ No	☐ Yes, describe below			

SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) *(Select one)*

☐ **Athlete shows NO EVIDENCE of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability.**

OR

☐ **Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.**

ATHLETE CLEARANCE TO PARTICIPATE (*TO BE COMPLETED BY EXAMINER ONLY*)

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete needs further medical evaluation please make a referral below and second physician for referral should complete page 4.

☐ **This athlete is ABLE to participate in Special Olympics sports without restrictions.**

☐ **This athlete is ABLE to participate in Special Olympics sports WITH restrictions. Describe →** _____

☐ **This athlete MAY NOT participate in Special Olympics sports at this time & MUST be further evaluated by a physician for the following concerns:**

☐ Concerning Cardiac Exam ☐ Acute Infection ☐ O_2 Saturation Less than 90% on Room Air

☐ Concerning Neurological Exam ☐ Stage II Hypertension or Greater ☐ Hepatomegaly or Splenomegaly

☐ Other, please describe:

Additional Licensed Examiner's Notes and Recommended (but not required) Follow-up:

☐ Follow up with a cardiologist ☐ Follow up with a neurologist ☐ Follow up with a primary care physician

☐ Follow up with a vision specialist ☐ Follow up with a hearing specialist ☐ Follow up with a dentist or dental hygienist

☐ Follow up with a podiatrist ☐ Follow up with a physical therapist ☐ Follow up with a nutritionist

☐ Other/Exam Notes:

		Name:
		E-mail:
Signature of Licensed Medical Examiner	Exam Date	Phone: License #:

Athlete Medical Form – **MEDICAL REFERRAL FORM**

(To be completed by a Licensed Medical Professional only if referral is needed)

Athlete's First and Last Name:_____

This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates further evaluation is required.

Athlete should bring the previously completed pages to the appointment with the specialist.

Examiner's Name:_____

Specialty:_____

I have been asked to perform an additional athlete exam for the following medical concern(s) - *Please describe:*

- ☐ Concerning Cardiac Exam
- ☐ Acute Infection
- ☐ O_2 Saturation Less than 90% on Room Air
- ☐ Concerning Neurological Exam
- ☐ Stage II Hypertension or Greater
- ☐ Hepatomegaly or Splenomegaly
- ☐ Other, please describe:

In my professional opinion, this athlete MAY now participate in Special Olympics sports (indicate restrictions or limitations below):

☐ **Yes** ☐ **Yes, but with restrictions** ***(list below)*** ☐ **No**

Additional Examiner Notes/Restrictions:

Examiner E-mail: _____

Examiner Phone: _____

License: _____

Examiner's Signature **Date**

This section to be completed by Special Olympics staff only, if applicable.

This medical exam was completed at a MedFest event? ☐ Yes ☐ No

The athlete is a Unified Partner or a Young Athlete Participant? ☐ Unified Partner ☐ Young Athlete

Sign me up!

Vinceremos
Therapeutic Riding Center

I can volunteer in the following areas at Vinceremos:

- o Lesson help (leading and sidewalking)
- o Parent/Rider Association
- o Barn maintenance or handyman/woman work
- o Lawn work
- o Special events (fishing tournaments, Fall Fest, summer camp)
- o Auction assistance
- o I have a special talent or skill that I could share (Tell us!)_____

_____

_____

_____

Name_____ Rider's Name_____

Best way to reach you_____