Miracles Therapeutic Riding Center

Thank you for your interest in Miracles Therapeutic Riding Center. We strive to provide a friendly, supportive, and effective program for all of our students and families.

About Miracles:

Our program is purposely kept small so that we can give the maximum attention to each and every student. We have been in business for since 2006 and we currently serve between 40 and 50 students a week. We have a herd of 7 fabulous horses. Every horse we have has been picked for their gentle disposition with the needs and safety of our students in mind. The service we provide is a very effective form of therapy. One reason for its effectiveness is the fact that most students think of it as fun, not as yet another therapy. We have seen non-verbal students speak for the first time to their horse. We have seen students leave their walkers and walk on their own. Students who have not been able to walk alone now walk their horses around the arena before their lesson. For those students with emotional issues, their horses understand and provide a safe and loyal friend. The horses teach the riders how to control their emotions to achieve the desired response. The bond between horse and rider is strong and unquestioned. Each of these successes make us cry with joy.

Typically, our students range in age from 2 years old to 60+ years old. Their special needs include physical, emotional and developmental disabilities. Many are non-verbal and/or non-ambulatory. If needed, we have a ramp to assist our students in getting on the horses. Some riders will need someone to lead the horse and a sidewalker on each side. We have a great staff of volunteers that help us with all of these activities. Other riders have progressed to the point that they are now independent riders. Each lesson is geared specifically to the student and their needs, even down to what horse they might ride.

We strongly recommend that every rider (and their families) commit to riding at least once a week. This frequency will quickly provide the desired improvement in strength, focus, balance, concentration and riding skills. As with any therapy, regular sessions provide the greatest benefit. Although we can be flexible when the need arises, we ask that you respect the lesson times. Our schedule is fairly full and requires a great deal of coordination to ensure that the volunteers and horses are available to provide the support needed for each rider.

Cancellation Policy

In order for Miracles to continue to provide high quality services to all of our students, we are changing our cancellation policy. This new policy is effective immediately.

Lessons are offered in 10-week sessions. For each 10-week session, a student will be allowed two absences, with 24 hour advanced notice that can be made up if we have availability. If you

must cancel or change your regular time, we request that you give us at least 24 hours' notice (more is better). We realize that this is not always possible in the event of sickness or an emergency. **In the event of a non-emergency cancellation with less than 24 hour notice or "no show – no call", you will be charged for the lesson with no possibility of a make-up lesson.** In the event of an emergency cancellation or sickness, we will make every attempt to schedule a make-up as quickly as possible. We will make every attempt to schedule a make-up class within one month of the missed lesson. Because our schedule is busy and we rely heavily on volunteers, it may not always be possible to do this. No refunds will be given.

While we do know that emergencies happen, please understand that your lesson fee supports our horses and allow us to continue to provide services to all of our students. Even though we know our students have fun riding and enjoy their time with the horses, first and foremost this is therapy and should be approached the same as other forms of therapy (regularity, timeliness, commitment, etc).

Early on, we did not charge for any cancelled lessons and almost had to close our doors because of the financial impact this had on Miracles. We don't want that to happen again as we know how important this therapy is to all of our students.

In the event that we need to cancel due to weather extremes (below 25 degrees, icy and snowy roads or extreme heat over 95 degrees), **we will charge the standard lesson fees**. However, every attempt will be made to schedule a make-up time whenever possible. Unfortunately, our costs are fixed regardless of the weather.

Payment:

We prefer that lessons be purchased in 10 lesson packages. Payment is due at the first lesson. Renewal packages are due at the time of the 10th lesson. If this causes undue hardship, please let me know and we will try to work something out. We try very hard to make sure that we can accommodate every rider. We operate on a very small margin but we never want to deny services because of payment issues if at all possible.

If you decide not to continue with the program, please give us as much notice as possible so that we can release your slot to another student and plan for any changes in income.

Whatever the needs of our students, we do our best to accommodate them in a safe and fun environment. If you ever have any questions or need to discuss any situation, please let me know.

Welcome to our Miracles family,
Chris Griffith
Program Director

Miracles Therapeutic Riding Center

(Operating at Sterling Equestrian, LLC, 11051 Jasper Road, CO 80026)
303.883.4667

Participant's Name _____ Date of Birth _____ Age_____
Male ___ Female ___ Phone #_____
Street _____ City _____ State ___ Zip _____
County _____ School Name _____
Email _____
Parent or Guardian Name(s) _____
Rider or Guardian's Employer _____
List Phone Numbers and whose number it is, if other than Participant:
Home # _____ If not student's #, whose is it? Name: _____
Work # _____ If not student's #, whose is it? Name: _____
Cell # _____ If not student's #, whose is it? Name: _____

How did you hear of our program? _____

Please describe limitations/concerns in these areas:
Physical function (e.g., ambulation, motor skills, balance, strength, tone, vision):
_____
_____
_____

Cognition and Processing (e.g., attention, touch/sensation, memory, speech and language, sensory integration, learning disabilities, developmental delays):
_____
_____
_____

Psychological, emotional, behavioral, social issues:
_____
_____
_____

Do you have previous riding experience? If so, please describe:
_____
_____

What are your goals for this program? What, specifically, do you want us to work on? (balance, strength, tone, sensory, emotional issues, etc.)
_____
_____
_____
_____

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PARTICIPANT'S CONSENT & RELEASE FORM

Consent for Emergency Medical Treatment

In the event emergency medical aid/treatment is required due to illness or injury while participating in the services of, or while being on the property of, Miracles Therapeutic Riding Center, I authorize MIRACLES THERAPEUTIC RIDING CENTER to secure and retain medical treatment and/or transportation if needed. This authorization includes any treatment deemed necessary by a treating health care professional and includes but is not limited to x-ray, surgery, hospitalization, and medication. In addition, I authorize MIRACLES THERAPEUTIC RIDING CENTER to release my/my child/my ward's records to any individual involved in medical treatment and/or necessary transportation.

Participant's Name _____Phone_____
In case of emergency, contact _____ Phone _____
or contact _____ Phone _____
or contact _____ Phone _____
Physician's Name _____ Phone_____
Health Insurance Name (optional) _____ Policy # _____

Date _____Participant Signature _____
(or signature of parent/guardian if participant is under age 18)

Liability Release

Under Colorado Law, an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to section 13-21-119, Colorado Revised Statutes.

_____(Participant's name) would like to participate in the MIRACLES THERAPEUTIC RIDING CENTER program. I acknowledge the risks and potential for risks in riding and working with horses. However, I feel that the possible benefits to myself/my child/my ward are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs, assigns, executors and/or administrators, waive and release forever all claims for damages against MIRACLES THERAPEUTIC RIDING CENTER and Sterling Equestrian, LLC, its Board of Directors, Advisory Board, Instructors, Therapists, Aides, volunteers, employees, agents, and representatives of any kind for any and all injuries, damages, claims, demands, causes of actions, law suits, and/or losses I/my child/my ward may sustain while participating in MIRACLES THERAPEUTIC RIDING CENTER program.

Date _____ Participant's Signature _____
(or signature of parent/guardian if participant is under age 18)

Photo Release (Optional)

I hereby consent to and authorize the use and reproduction by the Miracles Therapeutic Riding Center of any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.

Date _____ Participant's Signature _____
(or signature of parent/guardian if participant is under age 18)

Miracles Therapeutic Riding Center

303.883.4667

Dear Health Care Provider:

Your patient is interested in participating in supervised equine activities. In order to safely provide this service, we request that you complete (or update) the attached Participant Medical History one-sided 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.

Orthopedic
Atlantoaxial Instability. include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint Subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

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

Medical/Psychological
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Setting
Heart Condition
Hemophilia
Medical Instability
Medications . e.g. photosensitivity
Migranes
PVD
Poor Endurance
Respiratory Compromise
Recent Surgeries
Skin Breakdown
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patients participation in equine activities, please contact me at (303) 883-4667.

Sincerely,

Chris Griffith
Program Director

Miracles Therapeutic Riding Center

Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: ____ Weight: ____
Address: _____ Phone: _____
Parent/Guardian _____

Diagnosis: _____ Date of Onset: _____
Past/Prospective Surgeries: _____
Medications: _____
Seizures/Type: _____ Controlled: Y N Date of last Seizure: _____
Shunt Present: Y N Date of last revision: _____
Special Precautions/Needs: _____

Mobility: Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N Braces/Assistive Devices: _____
For those with Downs Syndrome: AtlantoDens Interval X-rays, date: _____ Result: + -
Neurologic Symptoms of AtlantoAxial Instability: _____
Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
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 PATH 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.
Name/Title: _____ MD DO NP PA Other: _____
Signature: _____ Date: _____
Address: _____
Phone: (__)_____ License/UPIN Number:_____