



MAJESTIC HILLS RANCH

“Heroes on Horseback”

RULES & REGULATIONS FOR RECREATIONAL THERAPISTS

We wish to thank you for your interest in Equine Assisted Activities and Therapies at Majestic Hills Ranch. We are sure you will find this to be a rewarding and beneficial experience for your patients. Before entering the program, Majestic Hills Ranch will need the following forms filled out completely: the Registration form, Medical History/Physician Release form (signed by referring physician), and the Emergency Medical Treatment form.

To ensure your patients receive the best treatment available while being in a safe environment we do request the following:

1. Wear close-toed shoes at all times when at the ranch. Long pants are preferred but shorts are acceptable. Please ensure the riders are dressed appropriately for the weather; wearing layers is best, and it is always windy at the ranch. If the participant gets cold, the therapy can lose its effectiveness. The patients will be required to wear a helmet while riding and MHR will provide one.
2. We encourage family members to come with the patient, to visit and watch their therapeutic sessions. The time spent at the ranch will be fun and relaxing for everyone. For safety reasons, if your patients bring children, someone must be dedicated to watching them at all times. The animals at the ranch can be very intriguing but sometimes dangerous for little ones.
3. If the patient needs to cancel a session, it is important to call two hours in advance; that way we can inform our volunteers if needed. Call Craig Swanson at **612-759-1840**.
4. If the weather is questionable every effort will be made to contact you to cancel the session. We cannot ride in rain or if the heat index is 90 degrees or above.
5. All new riders must have a one-on-one evaluation to review all materials, stated goals, behavior issues, triggers, how to handle behavior and sensory issues, etc. Safety training will be done in a group setting. The evaluation will assist the Program Director or Instructor in determining which horse and tack is appropriate for each participant.

Majestic Hills Ranch
24580 Dakota Avenue Lakeville, MN 55044
Mailing Address: 3001 Metro Drive Suite 480 Bloomington, MN 55425



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INPATIENT

RULES & REGULATIONS FOR PROGRAM PARTICIPANTS

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1. Wear close-toed shoes at all times when at the ranch. Long pants are preferred but shorts are acceptable. Please dress appropriately for the weather; wearing layers is best, and it is always windy at the ranch. If you get chilled, the therapy can lose its effectiveness. You will be required to wear a helmet while riding and MHR will provide one for you.
2. We encourage family members to come with you, to visit and watch your therapeutic sessions. Your time spent at the ranch will be fun and relaxing for everyone. For safety reasons, if you or your guests bring children, someone must be dedicated to keeping an eye on them. The animals at the ranch can be very intriguing but sometimes dangerous for little ones.

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REGISTRATION FORM

Veteran Name: _____

Branch of Service: _____ Age: _____ Race: _____

Address: _____

City, State, Zip: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Therapist: _____ Phone Number: _____

Referring Doctor: _____

Clinic / Hospital: _____

Learning more about you!

Do you enjoy being outdoors? Yes _____ No _____

Do you have any horse experience? Yes _____ No _____ How long ago? _____

How much experience? _____

Do you enjoy being around animals? Yes _____ No _____

If not, what animals would you prefer **not** to be around? _____

What are your interests: _____

Do you have any fears about being on a ranch? _____

Other? _____

Your primary reason for interest in Equine Assisted Activities and Therapies:

New form of therapy Relaxation Exercise Sport activity New challenge

Gaining: Strength Range of motion Circulation Motor skills

Balance Self confidence Hand-eye coordination

State your own reasons: _____

Signature of Veteran: _____ Date: _____

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All information is kept confidential in a locked file cabinet at all times



AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

Participant **Staff** **Volunteer**

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____

Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

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 Majestic Hills Ranch 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 emergency treatment

This authorization includes x-ray, surgery, hospitalization, medication and any 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, Parent, or Legal Guardian

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, Parent, or Legal Guardian



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PHYSICIAN RELEASE FORM

Veteran’s Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Allergies (examples: food, bee stings, animals, etc): _____

Height: _____ Weight: _____ Diagnosis: _____

Stated goals for Veteran participating in Equine Assisted Activities and Therapies:

1.) _____

2.) _____

3.) _____

Please circle all that apply to Veteran:

Mobility: Independent Ambulatory Crutches Walker Braces Wheelchair

Amputee Prosthesis Paraplegic PTSD Chemical Dependency

Other: _____

Please indicate any special precautions: _____

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

PHYSICIAN Signature: _____

PHYSICIAN Name (please print): _____



Therapist and Therapeutic Riding Program Manager Instructions and Suggestions for Veteran Office use only

Veteran Name: _____ Date: _____

Physical or Mental Challenges _____

Ambulatory Status: _____

Adapted Equipment Required: _____

Mounting/Dismounting Method: _____

Helpers required (indicate gait assistance needed...update as needed):

Type of Assistance	Date	Gaits	Date	Gaits	Date	Gaits
Leader and 2 sidewalkers						
Leader and 1 sidewalker						
Leader only						
Sidewalker						
Independent						

Riding Skills (indicate gait/task is complete...add to and update as needed):

Task	Date	Gaits	Date	Gaits	Date	Gaits
Horse can approach...not fearful						
Has interest to groom the horse						
Shows interest in getting on the horse						
Holds reins						
Maintains good posture						
Holds handhold						
Able to control horse						
Able to halt from the horse						
Able to circle at the...						
Rides without stirrups						
Able to maintain half seat						
Able to post at the...						
Knows diagonal or lead						
Able to steer over cavalletti						

Short Term Goals _____

Longer Term Goals _____

Rider can: walk: _____ sitting trot: _____ posting trot: _____ canter: _____

Horse Recommendations: _____

**Gaits Key: W – walk ST – sitting trot PT – posting trot C - canter