Hillsborough County Florida
CONSERVATION & ENVIRONMENTAL LANDS
PO Box 1110 Tampa, FL 33601-1110

Bakas Equestrian Center

"ANNUAL UPDATE/VERIFICATION of RIDER INFORMATION"

Attention Bakas Rider/Client:

This information is currently on file. Please check that it is correct in order for the rider application to be renewed, you must return this form along with the medical form filled out ENTIRELY, and signed by a doctor.

The packet includes the following pages:

1. Application
2. Program Participation Guidelines
3. Rider's Authorization for Emergency Treatment/Rider's Medical History and Physician's Statement
4. Physician Information/Verification
5. Rider Liability Release/Photo Release/Equine Professional Release
   - NOTE: All parents, guardians, and or caregivers who will be in attendance with riders need to fill out the Liability/Equine Professional Release form.
6. CDBG FORM

Please return completed application to Danielle Johnson, Sr. Recreational Therapist at the below address.

Bakas Equestrian Center
Attention: Danielle Johnson
11510 Whisper Lake Trail
Tampa, Florida 33626
Fax: (813) 264-8984
E-mail: JohnsonD@hillsboroughcounty.org

Also, please allow a minimum of seven working business days for your packet to be processed. If you should have any questions, please call me at (813) 264-3890.

Sincerely,

Danielle Johnson
Danielle Johnson, Sr. Recreational Therapist

APPLICATION

Today's Date: _____

Rider/Client: _____ DOB: _____

Parent/Guardian: _____

Home Address (Street): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Emergency Contact Information

Contact Name: _____ Email: _____

Home Phone: _____ Cell Phone: _____

☐ **PLEASE CHECK HERE IF THE ABOVE INFORMATION HAS *CHANGED* WITHIN THE LAST YEAR.**

PHOTO RELEASE

I give permission to Bakas Equestrian Center to use without limitation or obligation, photographs, film footage or tape recordings that may include my family or my child's image or voice for purpose of promoting or interpreting Bakas Equestrian Center programs.

Yes: _____ **No:** _____

PHONE LIST

Riders may need to be notified by phone about upcoming events or schedule changes. We may have a parent on the phone committee make these calls. Indicate if you would like to be notified.

Yes: _____ **No:** _____

As you know, in order to offer a quality program like this, we require a lot of volunteers. We require parent/family volunteers while riders participate as well as assisting with special events/committees. Your signature states you have read the requirements and consent to volunteering and signing up to a committee in order to help the Bakas Equestrian Center programs.

I have reviewed the information above and certify this information is true and correct.

_____ _____

Rider/Parent/Guardian Signature **Date**

PROGRAM PARTICIPATION GUIDELINES

In order for a rider to participate in this program, an equal amount of volunteer time must be put in by the adult rider or adult family volunteer. Volunteer tasks may include assisting with classes, maintenance around the barn, and mandatory help with fundraisers.

Monthly parent meetings are held at the Bakas Center. Check the schedule at the barn for the days and times. Participation in these meetings is vital_

Due to the waiting list to get into this program, riders with the most volunteer involvement may receive high priority when scheduled for classes.

If you feel you need to drop out of the program for an extended length of time, please notify us and we will schedule a rider on the waiting list to fill the spot. Riders with excessive absences will be dropped and replaced with a rider from the waiting list.

Riders will be periodically evaluated for their progress. During this evaluation, we will determine if a rider still requires our specialized services. If it is determined that a rider does not need our assistance, the rider will be promoted out of our program to allow for riders requiring it.

Riders that display behaviors that are abusive in a manner to horses, staff, or volunteers will not be allowed to participate. This is for the safety of everyone involved.

The undersigned, as self/parent(s) and/or guardian(s) of _____, hereby acknowledge and accepts the provisions of the following forms: Liability Release, Photo Release, Emergency Medical Treatment Release and Equine Professional Release, Volunteer Service, and Bakas Equestrian Center Guidelines.

Date:_____ Client/Participant:_____

Signature:_____
Client, Parent or Guardian

Signature:_____
Legal Guardian (if participant is a minor child)

RIDER'S AUTHORIZATION FOR EMERGENCY TREATMENT FORM

In the event emergency medical aid or 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 **Bakas Equestrian 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 treatment.

Rider/Client's Name: _____ Phone: ( ) _____
Address: _____
City: _____ State: _____ Zip: _____
Name of Parent/Guardian: _____

In the event I cannot be reached: Emergency Contact: _____ Phone: ( ) _____

Parent/Guardian Signature: _____ Date: _____

RIDER'S MEDICAL HISTORY AND PHYSICAN'S STATEMENT

Name: _____ Date of Birth: _____
Diagnosis: _____
Tetanus Shot: Yes____ /No_____ Date: _____ Height: _____ Weight: _____
Seizure Type: _____ Controlled: _____ Date of Last Seizure: _____
Medications: _____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking YES or No. If yes, please comment.

AREAS	YES	NO	COMMENT
Allergies			
Auditory			
Cardiac			
Circulatory			
Incontinence/Coordination/Balance			
Learning Disabilities			
Mental Impairment			
Muscular			
Neurological			
Orthopedic			
Psychological Impairment			
Pulmonary			
Speech			
Visual			
Sensation			
Other			

Mobility	Yes	No
Independent Ambulation		
Crutches		
Braces		
Wheelchair		

Please indicate any special precautions: _____
Any contagious diseases? _____

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

INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

NEUROLOGIC	COMMENTS	ORTHOPEDIC	COMMENTS
Chiari II Malformation		Atlanto-Axial Instabilities	
Hydrocephalus/shunt		Coxas Arthrosis	
Hydromyelia		Cranial Deficits	
Paralysis Due to Spinal Cord Injury		Heterotopic Ossification	
Seizure Disorders		Hip Subluxation/Dislocation	
Spina Bifida		Internal Spinal Stabilization Devices	
Tethered Cord		Kyphosis	
		Lordosis	
MEDICAUSURGICAL		Osteoporosis	
Allergies		Pathologic Fractures	
Cancer		Scoliosis	
Diabetes		Spinal Fusion	
Hemophilia		Spinal Instabilities/Abnormalities	
Hypertension		Spinal Orthoses	
Peripheral vascular Disease			
Poor Endurance		**SECONDARY CONCERNS**	
Recent Surgery		Acute Exacerbation of Chronic Disorders	
Serious Heart Condition		Age Two-Four Years	
Stroke		Age Under Two Years	
Varicose Veins		Behavior Problems	
		Weight Exceeds 250 lbs.	

For those with Down syndrome: Neurologic Symptoms of Atlantoaxial Instability: Present:_____ Absent: ____

PHYSICIAN'S VERIFICATION

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

Rider's Name: _____

Physician's Printed: _____

MD DO NP PA Other: _____ License/UPIN Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Physician's Signature: _____ Date: _____

CDBG FORM

Household Information

Household name: _____ Household size: _____

Complete address: _____

Head of Household Demographic Information

Indicate your race by checking the appropriate box:

RACE	White	Black/African American	Asian	American Indian/ Alaskan Native	Native Hawaiian/ Other Pacific Islander	Am. Indian/ Alaskan & White	Asian & White	Black African American & White	American Indian/ Alaskan & Black	Other/ Multiracial

Head of Household Female: _____YES _____ NO

Head of Household Hispanic Ethnicity: _____ YES _____ NO

Check the category box that best describes your qualifications for this program:

Disabled child ☐ Disabled adult ☐

DISABILITY: A physical or mental impairment that substantially limits one or more of the major life activities of such for an individual.

Income Information

Annual (gross) income range (total of all household members). Please check one:

Income Range	Below $12,600	Between $12,601- $20,949	Between $20,950- $33,500	Between $33,501- $39,499	Between $39,500- $63,200	Above $63,200

Acknowledgement and Disclaimer

I CERTIFY UNDER PENALTY OF PERJURY THAT INCOME AND HOUSEHOLD STATEMENTS MADE ON THIS FORM ARE TRUE. THE INFORMATION ON THIS FORM MAY BE VERIFIED.

PRINTED NAME _____ **Date** _____

SIGNATURE _____

The information you provide on this form is for Community Development Block Grant (CDBG) program purposes only and will be kept confidential. **WARNING:** Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government.