

Midwest Therapeutic Riding Program

### Stable Location

1117 N. Britton Road  
Union Grove, WI 53104

### Mailing Address

P.O. Box 085184  
Racine, WI 53408

### Phone & Fax

262-878-2000

### Email

[mtrpinc@aol.com](mailto:mtrpinc@aol.com)

[www.mtrpinc.org](http://www.mtrpinc.org)

Thank you so much for inquiring about our facility. Midwest Therapeutic is a therapeutic horseback riding program for children with physical, cognitive, and/or emotional disabilities. We offer two variations of the program — Hippotherapy and Therapeutic Riding.

Hippotherapy literally means ‘treatment with the help of a horse’: it is therapy that uses the horse’s gait as a tool. It is conducted by a specially trained occupational or physical therapist, thus it is a form of physical or occupational therapy. Typically, the client receives traditional therapy for approximately half the time, and the horse’s gait is used as the therapy tool for the remainder of the session; treatments last anywhere from 30 to 60 minutes, depending on the needs of the child. Hippotherapy provides a controlled environment and graded sensory input designed to elicit appropriate adaptive responses, and a foundation of improved neuromotor function and sensory processing. This form of therapy is used primarily to achieve physical goals, but also effects psychological, cognitive, communicative, and behavioral outcomes. Hippotherapy can be a billable insurance expense, depending on your plan’s benefits. Otherwise, the private pay cost is \$50 per half-hour session. Unfortunately, Medicaid, Title 19, and Katie Beckett *do not* cover hippotherapy.

With therapeutic horseback riding, the rider with special needs learns how to ride and control the horse. Therapeutic riding is conducted by riding instructors that have been trained to work with clientele with special needs. We like to get the child’s IEP so we can incorporate school goals into their riding lesson. The student benefits from the movement of the horse, and has fun, all at the same time! Sessions are thirty minutes long, and cost \$25; pre-payment is required unless prior arrangements have been made with the office. Your child will have a regularly scheduled weekly appointment.

To proceed, please fill out the enclosed forms. The ‘student medical history/physician’s statement’ is required for all clients. The physician’s prescription and ‘consent for hippotherapy services’ are only required for hippotherapy. You may fax the forms to us at 262.878.2000, or mail them to us at the *mailing address*. We will contact you to discuss the waiting list and or scheduling after we have received all the forms back.

We look forward to meeting you and your child!

### Our mission ...

Improving the lives of children with special needs through equine facilitate activities; providing individualized care to maximize the child’s potential

### Our motto ...

Making Dreams Come True!

*Directions from I-94: Exit Hwy. 20/Racine and travel west for approximately 7 miles to Britton Road. (Britton Road is west of Hwy. 45.) Turn left (south) on Britton Road. We are located on the Signature Arabians property, 1117 N. Britton Road. It is the second property on the left. We are closed Monday, Friday and Sunday.*



## Our Center's Weight Policy

Unfortunately, riding is not an appropriate activity for everybody and we have occasionally had to decline service to those for whom riding is contraindicated. As a member of NARHA (North American Riding for the Handicapped Association), we must follow NARHA guidelines. According to NARHA guidelines, riding is contraindicated if:

1. The staff is unable to safely manage the client in any situation, including emergency dismounts.
2. The safety or comfort of the horse is compromised.

The chart below shows the maximum weight per height that is appropriate for riding at our center. Those within the limit will be evaluated by staff to determine if riding is a safe and appropriate activity.

### Height and Weight Table

Females		Males	
Height	Weight	Height	Weight
4' 11" and under	140 pounds	5' 2" and under	155 pounds
5'0" - 5'1"	145 pounds	5'3"	160 pounds
5'2"	150 pounds	5'4" - 5'5"	165 pounds
5'3"	155 pounds	5'6"	170 pounds
5'4" - 5'5"	160 pounds	5'7"	175 pounds
5'6"	165 pounds	5'8"	180 pounds
5'7"	170 pounds	5'9" - 5'10"	185 pounds
5'8" - 5'9"	175 pounds	5'11"	190 pounds
5'10"	180 pounds	6'0"	195 pounds
5'11" and above	185 pounds	6'1" and above	200 pounds



# Midwest Therapeutic Riding Program

## Student Registration, Goals, and Liability Release Form



### Registration:

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home E-mail: \_\_\_\_\_

School Presently Attending: \_\_\_\_\_ Grade: \_\_\_\_\_

Parents or Guardians: \_\_\_\_\_ Relationship: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

\_\_\_\_\_ Relationship: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

In Case of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### Goals:

Why are you applying for participation in this program? What would you like to accomplish?

How did you find out about us?

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### Liability Release:

\_\_\_\_\_ (client's name) would like to participate in the Midwest Therapeutic Riding Program. I acknowledge the risks and potential risks of horseback riding. However, I feel that the possible benefits of myself/my son/my daughter/my ward, are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against MTRP, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Midwest Therapeutic Riding Program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client, Parent, or Guardian

### Photo Release:

I hereby consent to an authorize the use and reproduction by Midwest Therapeutic Riding Program of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client, Parent, or Guardian



# Midwest Therapeutic Riding Program

## Emergency Medical Treatment



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 Midwest Therapeutic Riding Program 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.

### Client Information:

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

In the event I cannot be reached:

Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_ Address: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

### Consent Plan:

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 below is unable to be reached.

Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client, Parent, or Guardian

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

### Non-Consent Plan:

I do not give my consent of 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:

\_\_\_\_\_

Non-Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client, Parent, or Guardian

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Please fill in one or the other in this area.

Student Medical History and Physician's Statement - page 1 of 2

To be completed annually by student's physician

**Medical History:**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Name of Parent or Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

\*\* For persons with Down Syndrome:

Negative Cervical X-ray for Atlantoaxial Instability. X-ray date: \_\_\_\_\_

Negative for clinical symptoms of Atlantoaxial Instability.

Tetanus Shot:  Yes  No Date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Seizure Type: \_\_\_\_\_ Controlled: \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

Medications: \_\_\_\_\_

Mobility: Independent Ambulation:  Yes  No Crutches:  Yes  No

Braces:  Yes  No Wheelchair:  Yes  No

Please indicate any special precautions: \_\_\_\_\_

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	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			

**Physician's Statement:**

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic ring 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, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician Name (please print): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Please submit to Midwest Therapeutic

Fax number: 262.878.2000

Mailing Address:  
P.O. Box 085184  
Racine, WI 53408

**PRESCRIPTION**

( X ) OCCUPATIONAL THERAPY                      ( ) PHYSICAL THERAPY

Patient's Name: \_\_\_\_\_                      DOB: \_\_\_\_\_

DIAGNOSIS: Please check one of the following.

If more than one diagnosis applies, please number in order of importance

- |  |  |
|--|--|
| _____ Hyolonia (728.9)                               | _____ Myelomeningocele lumber region (741.93)      |
| _____ Coordination Disorder (781.3)                  | _____ Cerebral Palsy: Spastic Diplegia (343.0)     |
| _____ Apraxia / Dyspraxia (784.69)                   | _____ Cerebral Palsy: Spastic Quadriplegia (343.2) |
| _____ Infantile Cerebral Palsy (343.9)               | _____ Cerebral Palsy: Spastic Hemiplegia (343.1)   |
| _____ Static Encephalopathy (349.9)                  | _____ Developmental Coord. Disorder (315.4)        |
| _____ Developmental Disorder (315.9)                 | _____ Multisystem Development Disorder (315.5)     |
| _____ Down Syndrome (758.0)                          | _____ Attention Deficit Disorder (314.00)          |
| _____ Cerebellar Alaxia (334.3)                      | _____ Autism MSDD (299.00)                         |
| _____ Infantile Spinal Muscular Atrophy (355.0)      | _____ Closed Head Injury (851.03)                  |
| _____ Other (please specify name and ICD code) _____ |  |

CONTRAINDICATIONS / PRECAUTIONS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FREQUENCY: \_\_\_\_\_                      DURATION (# of months): \_\_\_\_\_

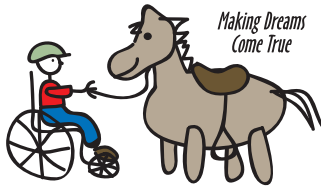
Physician's Signature: \_\_\_\_\_                      Date: \_\_\_\_\_

Physician's Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_                      State: \_\_\_\_\_                      ZIP: \_\_\_\_\_

Telephone Number: \_\_\_\_\_                      Fax: \_\_\_\_\_



Midwest Therapeutic Riding Program, Inc.  
P.O. Box 085184  
Racine, WI 53408  
262.878.2000

## HIPPOTHERAPY - CONSENT FOR SERVICES

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Street or P.O. Box

**Assignment of Benefits** — I hereby authorize Midwest Therapeutic Riding Program (MTRP) to release any information, both medical and financial, which is requested by my insurance company, trust, or responsible agency in relation to payment of my account.

**Payment of Account** — I assume financial responsibility for the services that I will receive at MTRP, regardless of third party coverage. I assume full financial responsibility in the event that insurance payment is denied in part or full by my health carrier. If I have no insurance coverage, I accept full responsibility for all of the services rendered.

**Cancellation Policy** — MTRP holds the right to assess a \$25.00 charge when a client fails to give prior notice of cancellation of any appointment. This charge will be the sole responsibility of the patient, parent, or guardian and will not be reimbursed by your insurance company.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient / Patient's Name

