The Luci Center
P.O. Box 936
Shelbyville, KY 40065

January 2013

Dear Participant:

Enclosed are the Rider Registration and Release Form along with the Medical History and Physician Statement. These forms must be completed in full, and a medical doctor must fill out all of the medical information for you in order for the paperwork to be valid. **All medical forms must be dated for the current year** in which you wish to ride. We must receive these forms back before we can schedule a class time for you in one of our Sessions.

I have listed below some information about our 2013 session classes. We recommend for our new students that they participate in a private class for their first session. We find that the one-on-one attention helps them to become more comfortable with the horses and classes. After they have completed their first session most of our students can participate in a group class and they enjoy the social interaction with other students. If you have any questions please feel free to give me a call at 502-220-4308.

Sincerely,

Becky Yost
The Luci Center
(502)-220-4308

Session length **4-6 weeks, 1 hour per week (Scheduled day and time)**

Lesson Fees:

4 Week Sessions	**Private $ 265.00 (4 weeks)**
	Group $ 155.00 (4 weeks)
6 Week Sessions	
	Private $ 400.00 (6 weeks)
	Group $ 230.00 (6 weeks)

The Luci Center

2013 Information

Class Schedule

Session 1: May 21 – June 29

Session 2: July 16 – August 24

Session 3: September 3 – October 12

Session 4: TBA

Lessons are for 4-6 weeks at a designated time

Private Lessons - $ 265 per 4 weeks and $400.00 per 6 weeks
Group Lessons (2- 4 riders) - $155 per 4 weeks and $230.00 per 6 weeks

Please contact The Luci Center for a rider application form or you may go to our website at www.thelucicenter.org and download the Rider Application Form.

All riders must have a fully completed application packet. This includes the Medical History and Physician Form that must be fully filled out by a medical doctor and signed by a medical doctor prior to riding. There are no exceptions.

If you are interested in participating in our classes, we do have a waiting list. Please give us a call at 502-220-4308 if you have any questions or would like to be added to our list.

Mailing Address
The Luci Center
PO Box 936
Shelbyville, KY
40066-0936

Physical Address
The Luci Center @ Moonshadow Farm
575 Moody Pike
Shelbyville, KY
40066-0936

502-220-4308
www.thelucicenter.org
lucicntr@aol.com

The Luci Center
A Therapeutic Riding Center
Love | Understanding | Care | Involvement

2013 Rider Candidate Form

Class Schedule

Session 1: May 21 – June 29
Session 2: July 16 – August 24
Session 3: September 3 – October 12
Session 4: TBA

Lessons are for 4 or 6 weeks at a designated time.
Private Lessons -
$265 per 4 week & $400.00 per 6 weeks
Group Lessons (2-4riders)-
$155 per 4 weeks & $230.00 per 6 weeks

First time riders are usually only eligible for a private class. Our riders are children and adults ages 3 and up. Physical and mental disabilities are accepted.

Please contact The Luci Center for a separate rider application form or you may go to our website at www.thelucicenter.org and download the Rider Application Form.

Name of Rider Candidate:
_____
Contact Name:_____
Address:_____
City/State/Zip:_____
Telephone:_____
Email:_____

Rider Candidate Info:
Age:_____
Gender: _____
Weight:_____

Diagnosis:_____
_____
_____

How did you hear about The LUCI Center?
_____
_____

All riders must have a fully completed application packet. This includes the Medical History and Physician Form that must be fully filled out by a medical doctor and signed by a medical doctor prior to riding. There are no exceptions.

FOR MORE INFORMATION
Call: (502)-220-4308
Visit our website: www.thelucicenter.org
Email: lucicntr@aol.com

Please Return *Fully* Completed Packet To:
The LUCI Center
P.O. Box 936
Shelbyville, KY 40066

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

The Luci Center
575 Moody Pike
P.O. Box 936
Shelbyville, KY 40065
502-220-4308 www.thelucicenter.org

Rider Registration and Release Form

Registration

Client Name: _____ Gender: O Male O Female

Date of Birth: _____/_____/_____ Age: _____

Mailing Address: _____ City, State, Zip: _____

Home Phone: (_____)_____ E-mail Address: _____

Work Phone: (_____)_____ Cell Phone: (_____)_____

Emergency Phone: (_____)_____

Parent or Guardian's Name(s):_____

Mailing Address: _____ City, State, Zip: _____

Phone: (____) _____

School or institution presently attending: _____

1. In case of emergency, contact person:_____ phone:_____

2. In case of emergency, contact person:_____ phone:_____

Liability Release

_____(Client's name) would like to participate in The Luci Center program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to 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 damage against The Luci Center, 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 The Luci Center.

Date: _____ Signature:_____
(Client, Parent or Guardian)

Photo Release

I hereby consent to and authorize the use and reproduction by The Luci Center of any and all photographs and any other audiovisual materials taken of my/my son/my daughter/my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Date: _____ Signature: _____
(Client, Parent or Guardian)

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Rider's Authorization for 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 **The Luci 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.

Client's Name: _____ Phone: _____

Address: _____

In the event, I cannot be reached, Contact: _____ Phone: _____

Contact: _____ Phone: _____

Physician's Name: _____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Policy #: _____

Select One Plan

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.

Date: _____ Consent Signature: _____

(Client, Parent or Guardian)

Print Name: _____ Phone: _____

Address: _____

Date: _____ Consent Signature: _____

(Client, Parent or 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: _____ Non-Consent Signature: _____

(Client, Parent or Guardian)

Print Name: _____ Phone: _____

Address: _____

A copy of the completed *Rider's Medical History and Physician's Statement* should be submitted with this form.

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Rider's Medical History and Physician's Statement

This form must be fully completed by a MEDICAL DOCTOR ONLY and signed by a MEDICAL DOCTOR ANNUALLY.*

Name: _____ Date of Birth: _____

Address: _____

Height: _____ **Weight**:_____ Tetanus shot? O Yes O No If yes, date: _____

Medications: _____

Name of Parent/Guardian: _____

Diagnosis: _____ Date of Onset: _____

Seizure type: _____ Controlled: O Yes O No Date of last seizure: _____

For Persons with Down Syndrome only:

O Negative Cervical X-ray for Atlantoaxial Instability X-ray date: _____

O Negative for clinical symptoms of Atlantoaxial Instability

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			
Other			

Mobility	**Yes**	**No**	**Comments**
Independent ambulation			**Please indicate any special precautions:**
Crutches			
Braces			
Wheelchair			

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.

Orthopedic

Spinal fusion
Spinal instabilities/abnormalities
Atlantoaxial instabilities
Scoliosis
Kyphosis
Lordosis
Hip subluxation and dislocation
Osteoporosis
Pathologic fractures
Coxas arthrosis
Heterotopic ossification
Osteogenesis imperfecta
Cranial deficits
Spinal orthoses
Internal spinal stabilization devices

Medical/Surgical

Allergies
Cancer
Poor endurance
Recent surgery
Diabetes
Peripheral vascular disease
Varicose veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (cerebrovascular accident)

Neurologic

Hydrocephalus/shunt
Spina bifida
Tethered cord
Chiari II malformation
Hydromyelia
Paralysis due to spinal cord injury
Seizure disorders

Secondary Concerns

Behavior problem
Age under two years
Age two – four years
Acute exacerbation of chronic disorder
Indwelling catheter

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

Physician Name (please print): _____
Physician Signature: _____ Date: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone: (_____)_____

This form must be fully completed by a MEDICAL DOCTOR ONLY and signed by a MEDICAL DOCTOR ANNUALLY.

Parent/Guardian Questionnaire for: _____

(Student's Name)

We want to learn more about our students and their abilities. Please take a moment to answer these questions. There are no correct or incorrect answers. Your input will assist us in meeting the student's needs and creating lessons that will keep them engaged and excited to learn.

1. These are some things they does well……

2. What do they like.

3. Describe your home life (does the student have siblings, attend day care/program or school, what occurs in an average day?)

4. In the next couple of months, we'd like to see the student accomplish these things…..

5. Let us know how independent the student is with the following, let us know if they have difficulty with these tasks or aspects of these tasks:

Grooming: (Brushing teeth, hair washing, washing face)

Bathing: (Amount of assistance if any, do they enjoy a bath or playing in the water)

Dressing: (Can they fasten clothing, determine appropriate clothing for the weather, tie their shoes)

Eating: (Can they finger feed, use utensils, sip from a cup? Do they spill food and drinks? Does your child like only particular foods, temperatures or textures?)

6. Can they use the telephone, do they know what to do in an emergency situation, and can the recognize community signs?

7. Do they participate in meal preparation, cleaning or household chores? (If so, describe) Is there a task you would like them to assist with at home?

8. What is their understanding of reading and math? (Can they recognize letters, sight words, read, recognize money, count money, make change?) Does the student have an allowance or purchase items at the store?

9. What hobbies or activities does the student enjoy? What activities do you like to do with them?

Thank you!