



Thank you for your interest in the Pegasus Project!

Pegasus Project is a NARHA Premier Accredited Center, providing therapeutic riding and equine assisted activities to those with special needs and disabilities. The program is designed to promote riding and horsemanship skills, taking into account each participant's needs. Approved applicants are evaluated and annual goals are developed for the participant.

Before an applicant can be considered for the Pegasus Project program, the enclosed forms must be completely filled out and returned to the Pegasus Project office (see mailing address at bottom of page).

- **Eligibility Requirements (for your reference)**
- **Participant's Medical History & Physician's Statement (Please include Information for Physician when submitting form)**
- **Authorization for Emergency Medical Treatment**
- **Application and Health History**
- **Photo Release**
- **Release of Liability**
- **Physical/Occupational Therapy Assessment (If available)**

Once all forms are received and verified for completeness, the applicant will be contacted for an assessment. If the applicant is suitable for therapeutic riding, the applicant will be enrolled in the program or put on the waiting list if there is not an available riding lesson slot. We do our best to accommodate all applicants.

After being accepted into the program, a riding contract will be issued to the participant /parent /guardian to be completed and returned to Pegasus Project with the session fee prior to the session starting, unless other arrangements have been agreed to. The cost of each **riding session** is **\$250.00** (one hour a week for 10 weeks). We do offer financial assistance, based on financial need. For additional information please call or email Leo Craven at 509-965-6990 / [admin@pegasusrides.com](mailto:admin@pegasusrides.com)

The Pegasus Project offers morning, afternoon and evening lesson times with four (4) quarterly sessions offered throughout the year and a two week break in between sessions.

If you have any questions regarding the application process, please contact the Pegasus Project office at the number listed below.

We thank you again for your interest!

Sincerely,

Pegasus Project

Pegasus Project ▪ 5808 Summitview Ave. #324, Yakima, WA 98908  
▪ Office: (509)965-6990 ▪ Fax: (509)965-0531



## **Eligibility Requirements**

Pegasus Project's goal is to provide safe and productive equine assisted activities for all its participants. If Pegasus Project cannot accommodate the participant's needs, or the act of riding or the environment will aggravate his/her condition, equine activities may not be appropriate.

As a NARHA Premier Accredited Center (PAC), Pegasus Project adheres to NARHA guidelines and standards. In conjunction with NARHA guidelines, we have established the following as eligibility requirements for the therapeutic riding program:

### **Mission Statement:**

All participants should have a diagnosed special need/disability in line with the following mission set forth by Pegasus Project:

“To provide quality therapeutic riding and equine related activities to people with special physical and emotional needs to improve their health and well being.”

### **Age Policy:**

**Minimum Age:** 4 years old for therapeutic riding lessons. There is not a maximum age. The only requirement is that the person is able to physically and safely perform what is required in a therapeutic riding lesson.

### **Weight Policy:**

The maximum weight for any rider that is appropriate for riding at the Pegasus Project is 200 lbs. People within that limit will be evaluated by staff to determine if riding is a safe and appropriate activity.

### **Precautions/Contraindications:**

If the movement associated with therapeutic riding will cause a decrease in the participant's function, an increase in pain or generally aggravate the participant's medical condition, it is not the activity of choice. If the equine assisted activities are detrimental to the participant or the equine, equine activities may be contraindicated, according to NARHA guidelines.

All participants are evaluated on an individual basis with regard to precautions and contraindications, as outlined by NARHA guidelines. All team members (participant, parent/guardian, NARHA Instructor, therapist, educator, physician and others) must be comfortable with the final decision to approve participation.

### **Further Considerations:**

These may include the experience and expertise of the NARHA instructor to address the needs of the participant, possessing a suitable equine for the participant, proper equipment, and availability of the appropriate number of volunteers for the participant. In addition, consideration will also be given to whether staff and volunteers are able to **safely manage the participant in any situation, including an emergency dismount.**

## Information for Physician

### Dear Healthcare provider:

Your patient, \_\_\_\_\_, is interested in participating in supervised equine assisted activities at the Pegasus Project therapeutic riding center.

In order to safely provide this service, Pegasus Project requests that you complete the attached Medical History and Physician's Statement form.

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  
(such as Harrington Rods)

### Neurological

Hydrocephalus/shunt  
Spina Bifida  
Tethered Cord  
Chiari II Malformation  
Hydromyelia  
Paralysis due to Spinal Cord Injury (above T-9)  
Uncontrolled Seizure Disorders

### Medical/Surgical

Allergies to Grasses, Animals and Dust  
Cancer  
Poor Endurance  
Recent Surgery  
Diabetes  
Peripheral Vascular Disease  
Varicose Veins  
Hemophilia  
Hypertension  
Serious Heart Condition  
Stroke (Cerebrovascular Accident)

### Secondary Concerns

Behavior Problems  
Age less than two years  
Age two – four years  
Acute exacerbation of chronic disorder  
Indwelling catheter

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine activities, please contact Pegasus Project at the address and phone number listed below.

Pegasus Project ▪ 5808 Summitview Ave. #324, Yakima, WA 98908

▪ Office:(509)965-6990 ▪ Fax: (509)965-0531

## Participant's Medical History & Physician's Statement (To be completed by Physician)

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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

Past/Prospective Surgeries: \_\_\_\_\_

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

Does participant have seizures?  Yes  No If yes, please note seizure type: \_\_\_\_\_

Are seizures controlled?  Yes  No Date of last seizure: \_\_\_\_\_

Does participant have a shunt?  Yes  No If yes, date of last revision: \_\_\_\_\_

Special Precautions/Needs: \_\_\_\_\_

Mobility: Independent Ambulation?  Yes  No /Assisted Ambulation?  Yes  No /Use of wheelchair?:  Yes  No

Braces/Assisted Devices: \_\_\_\_\_

*For those with Down Syndrome:* Date of last AtlantoDens Interval X- Rays: \_\_\_\_\_ Result:  Positive  Negative

Does participant display neurological symptoms of AtlantoAxial Instability?  Yes  No \_\_\_\_\_

**Please indicate current or past special needs in the following systems/areas, including surgeries:**

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

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

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Physician's Name/Title (please print): \_\_\_\_\_



**PEGASUS PROJECT**  
THERAPEUTIC RIDING

## AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Participant Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_

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

Allergies to medications: \_\_\_\_\_

Current medications: \_\_\_\_\_

In the event of an emergency, please contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

### Consent Plan

In the event of a medical emergency, I authorize Pegasus Project Therapeutic Riding Center and/or its designated agent to authorize such medical assistance as it deems necessary. I further authorize any licensed physician and/or medical facility to provide any medical or surgical care and/or hospitalization for the participant deemed necessary or advisable until I am available or able to provide more specific authorization.

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

(Participant, 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.

**\* Parent or legal guardian will remain on site at all times during equine assisted activities.**

In the event emergency treatment/aid is required, I wish the following procedures to take place:

\_\_\_\_\_  
\_\_\_\_\_

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



**PEGASUS PROJECT**  
THERAPEUTIC RIDING

## **PARTICIPANT APPLICATION & HEALTH HISTORY**

### **GENERAL INFORMATION**

Participant Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: M F

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Employer/School: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Parent/Legal Guardian(s): \_\_\_\_\_

Referral Source: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our program? \_\_\_\_\_

### **HEALTH HISTORY**

Primary Diagnosis: \_\_\_\_\_ Date of onset: \_\_\_\_\_

Secondary Diagnoses: \_\_\_\_\_ Date of onset: \_\_\_\_\_

Current or past seizures? \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

If yes, please elaborate on type, frequency, and method of control: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Past surgeries: \_\_\_\_\_

Recent imaging studies (X-ray, MRI, CT scan, etc.): \_\_\_\_\_

\_\_\_\_\_

Please indicate current or past considerations in the following areas (left hand column gives area and to the right gives examples of important information to include). Please use separate sheet if necessary.

		Yes	No	Comments
Vision	Glasses/contacts			
Hearing	Hearing aids, implants			
Sensation	Over- or under-sensitive			
Communication	ASL, speech delays, gesture			
Heart	Surgeries, implants			
Breathing	Asthma, oxygen			
Digestion	Gastronomy tube			
Elimination	Catheters, colostomy, incontinence			
Circulation	Varicose veins, hemophilia, reduced circulation			
Emotional/Mental Health	Depression, anxiety			
Behavioral	Aggression			
Pain	Headaches, joint pain			
Bone/Joint	Spinal surgeries, fusions, implants, osteoporosis, arthritis			
Muscular	Weakness, high tone, low tone			
Neurological	Seizures, ataxias, tremors			
Cognitive	Ability to follow one to multiple step requests			
Allergies	Hay, dust, dander			

**MEDICATIONS** (include prescription, over-the-counter; name, dose, and frequency):

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**Please describe the participant's abilities in the following areas** (include assistance required and/or equipment needed):

**PHYSICAL FUNCTION** (include mobility skills, such as the use of assistive devices or transfers, orthotics worn and purpose, etc):

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**PSYCHO/SOCIAL FUNCTION** (include daily activities, such as work or school – including grade completed, leisure interests, relationships, family structure, support system, companion animals, fears/concerns, etc.):

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**GOALS** (What would you/participant like to accomplish through riding or hippotherapy? Feel free to include other therapy goals and IEP objectives, etc.):

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

(Participant or Parent/Guardian)



## PHOTO RELEASE

Participant Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### **Consent:**

I hereby consent to and authorize the use and reproduction by the Pegasus Project Foundation of any and all photographs, digital reproductions, and any other audio/visual material taken of me/my son/my daughter/my ward for promotional material, whether electronic, print, digital or electronic publishing via the Internet, education activities, exhibits or for any other use for the benefit of the Pegasus Project for an unlimited period of time and without monetary compensation or other remuneration.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(If under 18 years old, parent or legal guardian must sign)

### **Non-Consent:**

I do not consent to and authorize the use of any and all photographs and any other audio/visual materials taken of me for promotional material, education activities, exhibits, or for any other use for the benefit of the program.

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

# LIABILITY RELEASE, INDEMNIFICATION, AND HOLD HARMLESS AGREEMENT

I fully understand and recognize the existence of each of the following risks and hazards associated with being around horses and horseback riding (these risks and hazards shall hereinafter collectively be referred to as the “*Inherent Risks*”):

- a. The activities of horseback riding and/or being near a horse involve numerous inherent dangers and risks, both foreseen and unforeseen, of injury and death to me (and/or my child);*
- b. Horses, like all other animals, irrespective of their training and usual past behavior and characteristics, may act and react in unpredictable and dangerous ways, including, but not limited to, rearing, bucking, and running away;*
- c. Horseback riding on any type of terrain can be dangerous to both me (and/or my child) and that this danger increases when riding a horse fast, such as at a canter (lope) or at a gallop;*
- d. While horseback riding, even at slower paces, my (and/or my child's) horse may stumble, be thrown off balance, get caught in a hole or rut, fall, or otherwise be dangerous to me; and*
- e. While horseback riding, I (and/or my child) may, at any time, lose control or fall off of my (and/or my child's) horse or have a collision.*

In light of these understandings and recognitions and in consideration of me (and/or my child) being permitted to participate in and/or serve as a volunteer for horseback riding and horse-related activities (“*Subject Activities*”) provided and/or coordinated by Pegasus Project Foundation (d/b/a Pegasus Project Foundation Therapeutic Riding Center), do for myself (and/or my child) and my (and/or my child's) heirs, personal and legal representatives, administrators, and assigns, hereby:

1. Recognize the *Subject Activities* are inherently dangerous and personally assume all risks, including, but not limited to, the above-stated *Inherent Risks*, whether foreseen or unforeseen, associated with my (or my child's) participation in the *Subject Activities*; and
2. Forever (i) RELEASE any and all liability of Pegasus Project Foundation and its successors, assigns, members, directors, officers, employees, volunteers, instructors, therapists, agents, sponsors, and affiliates (hereinafter collectively referred to as “*Releasee*”), (ii) DISCHARGE and COVENANT NOT TO SUE the *Releasee*, and (iii) hold and save HARMLESS and INDEMNIFY *Releasee* from and against any and every liability, claim, injury, loss, damage, expense, demand, action, and cause of action, of whatsoever kind or nature, arising out of or related to any such loss, damage, or injury, including death, that may be sustained by me (or my child), for whatever reason, while participating in the *Subject Activities*, whether such damages are the result of *Releasee's* negligence or any other cause.

I further state that (i) I am of lawful age and legally competent to sign this Agreement, (ii) I understand the terms of this Agreement are contractual and not a mere recital; (iii) this Agreement contains the entire agreement between myself and *Releasee*; and (iv) if I am executing this Agreement on behalf of a child, that I am the legal guardian of said child and authorized to execute this Agreement in said capacity. In addition, I agree that nothing about this Agreement limits the protections afforded to *Releasee* by Washington State's Equine Liability Law, as such is currently codified at RCW 4.24.530 - .540 and hereafter amended.

**IN SIGNING THIS AGREEMENT, I HEREBY ACKNOWLEDGE AND REPRESENT, THAT I HAVE READ THIS AGREEMENT, UNDERSTAND AND ACCEPT THE AGREEMENT'S TERMS, AND AM VOLUNTARILY ENTERING INTO THIS AGREEMENT.**

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

Name (Print): \_\_\_\_\_

Child's Name (*if applicable*): \_\_\_\_\_



**PEGASUS PROJECT**  
THERAPEUTIC RIDING

## PHYSICAL/OCCUPATIONAL THERAPY ASSESSMENT

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

History of therapy interventions: \_\_\_\_\_

\_\_\_\_\_

*Please describe the following functional abilities:*

Sitting balance (head/trunk control, balance reactions, support needed): \_\_\_\_\_

\_\_\_\_\_

ROM measurements: \_\_\_\_\_

Mobility (with & without assistive devices): \_\_\_\_\_

\_\_\_\_\_

Sensory systems: \_\_\_\_\_

\_\_\_\_\_

Equipment (when first used, purpose, present use): \_\_\_\_\_

\_\_\_\_\_

Communication methods used: \_\_\_\_\_

Present primary therapy goal: \_\_\_\_\_

\_\_\_\_\_

Precautions and/or contraindications: \_\_\_\_\_

\_\_\_\_\_

Signature & Title: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist's Name (please print or type): \_\_\_\_\_ Phone: \_\_\_\_\_

School, Center or Organization: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_