



## WELCOME TO BAKAS!

(As of 2/2010, the Annual Application fee is \$10. Make the check out to Bakas.)

Attention New Bakas Rider:

Thank you for your interest in the Bakas Equestrian Center, Horses for Handicapped. Enclosed, you will find an application/medical form.

Please be aware, Bakas requires all families or a representative of the family to fulfill the following requirements to participate in riding activities. The *minimum* requirements are:

- Attend a mandatory Orientation at Bakas.
- Join at least one Committee for the 2010 Riding Season.
- Attend a *minimum* of 2 Parent/Adult Rider meetings during the 2010 Riding Season.
- Volunteer an equivalent number of hours as the Rider who participates in the program.

Hillsborough County, Bakas staff, Parents, and Riders have established these policies in order to continue to offer this quality horseback riding program. The 2010 Riding Season runs from September 2009 through June 2010. Classes are scheduled in 30 minute lessons once a week for approximately four weeks. The cost will be \$40 (*\$10 per lesson*). Orientations are typically held the first Saturday of each month from 9:00 a.m. to 10:30 a.m. Parent meetings are typically held the first Wednesday of each month at 6pm at Bakas (see posted time and place at barn). Please RSVP when signing up for the Orientation.

*Please fill out the enclosed medical form ENTIRELY.* Your doctor must review pages 6 and 7 and sign page 7 in order for your medical form to be complete. *The Rider's height and weight must be completed or this form will be returned to you.* This form is due to Bakas annually.

Parent orientations are typically held on the 1<sup>st</sup> Saturday of each month from 9:00 a.m. to 10:30 a.m. *Please call for exact date.* Please check the Orientation date below that you will be attending. New Riders will not be placed in class until a family member has completed the Orientation requirement.

### **Orientation Requirement:**

Saturday, May 1, 2010 (9:00 a.m. to 10:30 a.m.)

Saturday, June 5, 2010 (9:00 a.m. to 10:30 a.m.)

Saturday, Sept. 4, 2010 (9:00 a.m. to 10:30 a.m.)

Saturday, Oct. 2, 2010 (9:00 a.m. to 10:30 a.m.)

Please return the information requested to Dani at the address or fax below so we can consider you for the next available riding session. When faxing, it is best to call us to confirm receipt.

Thank you – Bakas Staff

11510 Whisper Lake Trail • Tampa, Florida 33626 • (813) 264-3890 • Fax (813) 264-8984  
e-mail: [horsebakas@yahoo.com](mailto:horsebakas@yahoo.com) • [www.bakasridingcenter.com](http://www.bakasridingcenter.com)  
Hillsborough County Parks, Recreation and Conservation Department

The Hillsborough County Parks, Recreation and Conservation Department are offering horseback riding for the disabled at the Bakas Equestrian Center. Riders must be at least 4 years old, be physically or developmentally delayed, and meet our requirements. There is a 250 lb. weight limit for riders.

- You must fill out ALL of the attached forms including the medical form signed by a doctor. Also, complete the PARENT/GUARDIAN RELEASE FORM, PHOTO RELEASE, EMERGENCY MEDICAL TREATMENT RELEASE, AND PARENT QUESTIONNAIRE. Riders with Down syndrome require an additional medical form for an Atlanto-Axial X-ray. Each of these releases must have a signature and be dated.
- **All of these forms must be returned together in order for the rider to be considered to participate.**
- The application for riding must be renewed every twelve (12) months.
- Riders should wear jeans, must wear shoes with a heel, and an approved ASTM-SEI riding helmet. We can supply helmets and boots, if needed.

As you may know, in order to offer a quality program like this, we require lots of volunteers. We require that parents volunteer while riders participate and assist with special events. We hope you will take the time to review and fill out the forms. Horseback riding is very beneficial to most handicapped individuals. All classes are supervised by at least one NARHA certified riding instructor.

For more information, contact Beth Harre-Orr at (813) 264-3890 or fax (813) 264-8984.  
E-mail: [horsebakas@yahoo.com](mailto:horsebakas@yahoo.com)

**Registration**

Rider/Client: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone:(\_\_\_\_) \_\_\_\_\_ Work Phone:(\_\_\_\_) \_\_\_\_\_ Cell:(\_\_\_\_) \_\_\_\_\_

Emergency#:(\_\_\_\_) \_\_\_\_\_ Parents/Guardian:(\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_

School or Institution or employment presently attending: \_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

contact: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

E-mail address: \_\_\_\_\_

***Your e-mail address will only be used for notification of current schedules changes, and issues pertaining to you personally. We do not participate in mass mailings.***

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**VOLUNTEER SERVICE**

**The required volunteer hours may be performed in the following manner:**

- |                                    |  |
|------------------------------------|--|
| Side Walking                       | Straightening up Feed Room, Tack Room and Office |
| Cleaning Helmets                   | Cleaning Bathrooms                               |
| Sweeping Barns                     | Feeding Animals                                  |
| Cleaning Stalls                    | Washing Horses                                   |
| Washing Blankets, Pads, and Towels | Mending Fences                                   |
| Painting Barn                      | Help put Newsletter Together                     |
| Get Other Parents Involved         | Organizing Fundraisers                           |

**Parents are required to help with fundraisers by:**

- |  |                               |
|--|-------------------------------|
| Soliciting Donations                     | Recruit Other Volunteers      |
| Picking up Items                         | Hand out Flyers to Advertise  |
| Preparing Food and Bringing it to Events | Contact Media to Cover Events |
| Cook or Grill at Events                  |                               |

**EVERY RIDER MUST PROVIDE A VOLUNTEER TO ASSIST WITH SPECIAL EVENTS, SUCH AS CONCESSION STANDS AT HORSE SHOWS, FUNDRAISERS, ETC.**

**I UNDERSTAND AND I MUST ASSIST EVERY TIME MY CHILD/SELF RIDES.**

\_\_\_\_\_  
**Parent/Guardian Signature                      Date**

**VOLUNTEERING IS VITAL FOR THIS PROGRAM TO SURVIVE, PLEASE DO YOUR PART AND HELP OUT.**

**CONSENT/NON-CONSENT PLAN**

***IF YOU DO NOT GIVE CONSENT FOR EMERGENCY MEDICAL TREATMENT, YOU MAY NOT PARTICIPATE. (This authorization includes x-ray, surgery, hospitalization, medication, and any treatment deemed "life saving" by the physician. This provision will be invoked if the emergency contact person below is unable to be reached.)***

**CONSENT PLAN:**

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Print Name: \_\_\_\_\_ Phone:(\_\_\_\_)\_\_\_\_\_  
Address: \_\_\_\_\_  
Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_  
**Parent/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:

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

Print Name: \_\_\_\_\_ Phone:(\_\_\_\_)\_\_\_\_\_  
Address: \_\_\_\_\_  
Date: \_\_\_\_\_ Non-Consent Signature: \_\_\_\_\_  
**Parent/Guardian**

## 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 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 – Horses for Handicapped 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.

Client's Name: \_\_\_\_\_ Phone:(\_\_\_\_)\_\_\_\_\_

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

Name of Parent/Guardian:\_\_\_\_\_

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

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

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

Health Insurance Co.:\_\_\_\_\_ Policy#:\_\_\_\_\_

Parent/Guardian Signature:\_\_\_\_\_ Date:\_\_\_\_\_

**RIDER'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT**

To be completed annually:

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

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

Name of Parent/Guardian:\_\_\_\_\_

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

Tetanus Shot: Yes\_\_\_\_\_, date:\_\_\_\_\_ No\_\_\_\_\_ 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	COMMENTS
Allergies			
Auditory			
Cardiac			
Circulatory			
Incontinence/Coordination/Balance			
Learning Disabilities			
Mental Impairment			
Muscular			
Neurological			
Orthopedic			
Psychological Impairment			
Pulmonary			
Speech			
Visual			
Other			

Mobility: Independent Ambulation: Yes:\_\_\_\_\_ No:\_\_\_\_\_

Crutches: Yes\_\_\_\_\_ No\_\_\_\_\_

Braces: Yes\_\_\_\_\_ No\_\_\_\_\_

Wheelchair: Yes\_\_\_\_\_ No\_\_\_\_\_

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

Any contagious diseases?\_\_\_\_\_

## 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	
<b>MEDICAL/SURGICAL</b>		Osteoporosis	
Allergies		Pathologic Fractures	
Cancer		Scoliosis	
Diabetes		Spinal Fusion	
Hemophilia		Spinal Instabilities/Abnormalities	
Hypertension		Spinal Orthoses	
Peripheral Vascular Disease			
Poor Endurance		<b>SECONDARY CONCERNS</b>	
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.	

**If the student has Down syndrome, an additional Atlanto-Axial Dislocation x-ray form is required.**

### PHYSICIAN'S VERIFICATION

In my opinion, this person can receive riding instructions under proper supervision.	
Rider's Name: _____	
Physician's Printed Name: _____	
Address: _____	
City: _____ State: _____ Phone: (____) _____	
Physician's Signature: _____ Date: _____	

**Please return the entire completed application to:**

**Bakas Equestrian Center  
 11510 Whisper Lake Trail  
 Tampa, Florida 33626  
 Phone: (813) 264-3890  
 Fax: (813) 264-8984**

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