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

Bakas Equestrian Center

"WELCOME TO BAKAS"

Attention New Bakas Rider:

Thank you for your interest in Hillsborough County's Conservation and Environmental Lands Management Department Bakas Equestrian Center, hereinafter referred to as "THE CENTER" New Rider Packet. This packet must be completed on an annual basis (12) month period.

The packet includes the following pages:

1. Instruction
2. Registration
3. 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.
4. Volunteer Service
5. Program Participation Guidelines
6. Rider's Authorization for Emergency Treatment/Rider's Medical History and Physician's Statement
7. Physician Information/Verification
8. CDBG FORM

After you have reviewed the application and have determined that you are capable of meeting the requirement, you may apply to be considered for rider placement. This can be done by completing and returning the attached application to:

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

INSTRUCTIONS

Please read the following instructions prior to completing the attached application.

A completed Application must be submitted in order to be considered for rider placement. The primary function of this application is for the County staff to understand and incorporate riders in sessions geared towards their specific needs.

Important

The County offers horseback riding lessons for disabled persons at the Bakas Equestrian Center. The Center requires all families or a representative of the family to fulfill/meet the m*inimum requirements*:

Rider/Client

- 4 years of age and up.
- Not exceed 250 lbs.
- Be physically or developmentally delayed.
- Doctor review of pages 6 and 7 and execute page 7 in order for your annual medical form to be complete. The rider's height and weight must be completed or this form will be returned to you.

Family Member/Family Representative

- Attend a mandatory orientation at Bakas.
- Join at least one committee for the riding season.
- Attend a *minimum* of two parent/adult rider meetings during the riding season.
- Volunteer an equivalent number of hours as the rider who participates in the program.

Hillsborough County BOCC, Bakas Equestrian Center staff, parents, and riders have established policies and procedures in order to continue to offer this quality horseback riding program.

- The riding season runs from September 1st through June 30th.
- Classes are scheduled for 30 minutes once a week for approximately four weeks.
- The cost will be $10 per lesson.
- Orientations for new riders will be done when the attached paperwork is dropped off or when the rider comes in for their first class.
- Parent/rider meetings are typically held the 2nd Thursday of each month (see posted time and place at barn).
- Riders should wear jeans, must wear shoes with a heel, and an approved ASTM-SEI riding helmet. The Center may supply helmets and boots if needed.

Fees

There are no fees directly associated with submitting an Application. However, there is a $10 fee for each session. Once you are approved/confirmed to attend the session of your choice:

1. Please make every effort to submit payments three (3) days prior to the start of the session to avoid any potential interruptions in service.
2. If you do not show-up at your confirmed session you are still responsible for the payment of that session.
3. To avoid miscommunication and better serve other riders, notifications of cancellations should be in writing – either by email, fax or mail. Please note cancellations are non-refundable; however, staff will make every reasonable accommodation to reschedule the session.

REGISTRATION

Today's Date: _____

Rider/Client Information

Rider/Client: _____ DOB: _____ Age: _____ M/F: _____

Home Address (Street): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Parent/Guardian Information

Parent/Guardian: _____ Email: _____

Home Phone: _____ Cell Phone: _____

Parent/Guardian Address (if different than above): _____

School, Institution, or Employment Presently Attending: _____

School/Institution/Employee Phone: _____

Emergency Contact Information

Contact Name: _____ Email: _____

Home Phone: _____ Cell Phone: _____

How did you hear about the Bakas Equestrian Center? _____

Your e-mail address will only be used/or notification of current schedules changes, and issues pertaining to you personally. The Center does not participate in mass mailings.

Self/Parent/Guardian Signature: _____ Date: _____

RIDER LIABILITY RELEASE

The undersigned, self or as parent/guardian of _____ for and in consideration of participation in the special equestrian program forthe handicapped, hereby forever releases, acquits, discharges, and hold harmless, Hillsborough County BOCC, Conservation and Environmental Lands Management Department of Hillsborough County, and Bakas Equestrian Center, their directors, employees, representatives, and assigns, for any and all claims for loss, demands, damages and any injuries of any nature whatsoever which the undersigned may now or in the future have against Hillsborough County BOCC, Conservation and Environmental Lands Management Department of Hillsborough County, and Bakas Equestrian Center their directors, employees, representatives, and assigns account of any personal injuries, physical or mental conduct, known or unknown, to the person and treatment thereof, as a result of or in any way growing out of the acts, including negligence or gross negligence

_____ I do consent
_____ I do not consent **Signature:** _____ **Date:** _____

PHOTO RELEASE

I hereby consent to and authorize the use and reproduction by Bakas Equestrian Center of any or all photographs and any other audiovisual materials taken of me, my son or daughter, or my ward; which may be used for promotional printed material, educational activities or for any other use for the benefit of the program.

_____ I do consent
_____ I do not consent **Signature:** _____ **Date:** _____

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. Please indicate if you would like to be notified. **Yes** _____ **No** _____

EQUINE PROFESSIONAL RELEASE

KNOWN ALL MEN BY THESE PRESENT, THAT _____, who resides at _____ (herein after referred to as "participant") desires to engage and does hereby engage the services of Bakas Equestrian Center, and the Hillsborough County Conservation and Environmental Lands Management Department (herein after referred to as "Equine Professional"), located at 11510 Whisper Lake Trail, Tampa, Florida 33626, to instruct the participant in any and all equine activities.

IN AND FOR CONSIDERATION OF THE ABOVE SERVICES, participant hereby does and forever and finally release, remise, acquit, satisfy and forever discharge Equine Professional of and from all manner of action and actions, cause and causes of action, suit, debts, dues, sums of money, bonds, billings, contracts, controversies, agreement, promises, damages, variances, judgments, executions, claims and demands whatsoever, in law or in equity, which may arise or might in the future arise or herein after may arise for or against the Equine Professional for the services stated above.

This document is meant to be a full and complete release from any and all liability that may arise from instruction to the Participant on how to properly ride, manage, and care for horses or participate with or near horses. This release is given freely and voluntarily by the Participant and is meant to remain in existence throughout the duration of any instruction.

WARNING

Under Florida Law, an equine activity sponsor or professional **is** not liable for an injury to, or the death of, a participant in equine resulting from the inherent risks of equine activities.

Self/Parent/Guardian Printed Name: _____

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 event
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.

_____ _____

Self/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 "lifesaving" 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:_____
Self/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:_____
Self/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 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.

Client's Name: _____ Phone: ( ) _____
Address: _____
Name of Parent/Guardian: _____
In the event I cannot be reached: Emergency Contact: _____ Phone: ( ) _____
Physician's Name: _____
Preferred Medial Facility: _____
Health Insurance Co.: _____ Policy#: _____

RIDER'S MEDICAL HISTORY AND PHYSICAN'S STATEMENT

To be completed annually:
Name: _____ Date of Birth: _____
Address of Parent/Guardian: _____
Diagnosis: _____
Tetanus Shot: Yes____ /No_____ Date: _____ Height: _____ Weight: _____
Seizure Type: _____ Controlled: _____ Date of Last Seizure: _____
Shunt Present: Yes____ /No_____ Date of last revision: _____

Medications (include prescription and over-the-counter; name, dose and frequency

_____
_____
_____

Physical Function (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

_____
_____
_____

Psycho/social Function (e.g., work/school including grade completed, leisure interests, relationships-family structure, support system, companion animals, fears/concerns, etc.

_____
_____
_____

Goals (i.e. why are you applying for participation? What would you like to accomplish?)

_____
_____
_____

Signature: _____ Date: _____

Continuation from page 7

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			
Sensation			
Other			

Mobility

	Yes	No
Independent Ambulation		
Crutches		
Braces		
Wheelchair		

Please indicate any special precautions: _____

Any contagious diseases? _____

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.

BG

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