



## CASSIDY'S CAUSE PROGRAM APPLICATION

# Application Process & Policies

6075 Clinton Road · Paducah, KY 42001 · 270.554.4040 · 270.554.0023 Fax

Thank you for your interest in becoming a participant at Cassidy's Cause Therapeutic Riding Academy, a non-profit providing horse therapy for youth & adults with disabilities.

### Application process:

- Complete this application & forms
- Receive physician's release
- Submit completed forms to
  - email [dara@cassidyscause.org](mailto:dara@cassidyscause.org)
  - fax 270.554.0023
  - bring/mail to 6075 Clinton Road

*Once all the paperwork is received, Dara will contact you to schedule an evaluation.*

- In-person evaluation

Program openings are limited and based on available class times and instructors. Following the evaluation, prospective participants will be placed into a class or onto a program waiting list.

**Horse Selection:** Matching a participant with the right horse is based upon safety, the horse's size/build/temperament/health, lesson objectives, and the participant's weight, balance, and coordination. Some participants will not be able to ride, but will focus their lessons on groundwork with a horse.

**Dress Code:** Participants must wear an ASTM/SEI approved helmet (provided by Cassidy's Cause), closed-toe shoes or boots (preferably with heels), and non-slippery pants or long shorts.

**Sessions:** Each class is ~1 hour, and most classes are small groups of 2-6 participants. Lessons are scheduled for the same day and time of week for the length of each session. There is at least one week off between sessions, with extended breaks in August and December. Classes are not scheduled during the Spring and Fall breaks of McCracken County Schools. Makeup classes will only be offered when a holiday (i.e. Memorial Day) falls during scheduled classes, or classes are canceled due to severe weather.

- Session 1 (6 weeks): January/February
- Session 2 (6 weeks): March/April
- Session 3 (6 weeks): May/June
- Session 4 (6 weeks): June/July
- Session 5 (6 weeks): September/October
- Session 6 (3 weeks): November

**Fees:** There is a \$200 charge for each six-week session, or a \$100 charge for the three-week session. Sliding scale fees and scholarships based on the financial need of a participant's family are available. Request for financial assistance must be made with the Executive Director prior to the start of a session.

**Attendance:** It is important to let us know if you can not make a lesson in advance, and to arrive promptly on time. Call the office (270.554.4040) or the barn cell (270.557.6624) as soon as possible if you can not make it to class.

**NO SMOKING ALLOWED IN/NEAR THE BARN**



# CASSIDY'S CAUSE PROGRAM APPLICATION

## Participant Application

6075 Clinton Road · Paducah, KY 42001 · 270.554.4040 · 270.554.0023 Fax

Date \_\_\_\_\_

Legal Name \_\_\_\_\_ Preferred Name (Nickname) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Participant is a  Minor  Independent Adult  Adult with a legal guardian

Employer/School \_\_\_\_\_ Grade Level \_\_\_\_\_  
if a student

Home Address \_\_\_\_\_

City

State

Zip

Participant's Phone or Email \_\_\_\_\_

.....

Parent/Guardian Name(s) & Relationship to Participant

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

Address (if different from above) \_\_\_\_\_

City

State

Zip

Check the box for your best contact method

Email \_\_\_\_\_

Additional Email \_\_\_\_\_

Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Referral? \_\_\_\_\_

How did you hear about Cassidy's Cause?

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

**I consent to Cassidy's Cause maintaining this information in their database, and will provide updated contact information to the organization if it changes.**

\_\_\_\_\_  
Signature of participant or parent/guardian

Date \_\_\_\_\_





CASSIDY'S CAUSE PROGRAM APPLICATION

# Participant Health History

6075 Clinton Road · Paducah, KY 42001 · 270.554.4040 · 270.554.0023 Fax

**Primary Condition(s):**

*Diagnosed disability/disabilities*

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**Current Medications:**

*Include prescription and over-the-counter, name, dose, & frequency*

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↓ Check current/past special needs in the following areas:

*Comments*

<input type="radio"/> Vision	
<input type="radio"/> Hearing/Auditory	
<input type="radio"/> Tactile Sensation	
<input type="radio"/> Communication	
<input type="radio"/> Heart/Cardiac	
<input type="radio"/> Breathing	
<input type="radio"/> Digestion	
<input type="radio"/> Elimination	
<input type="radio"/> Circulation	
<input type="radio"/> Pain	
<input type="radio"/> Bone/Joint	
<input type="radio"/> Muscular	
<input type="radio"/> Mobility	
<input type="radio"/> Balance	
<input type="radio"/> Thinking/Cognition	
<input type="radio"/> Learning Disability	
<input type="radio"/> Emotional Control	
<input type="radio"/> Mental Health	
<input type="radio"/> Attention Span	
<input type="radio"/> Behavioral	
<input type="radio"/> Self-Harm	
<input type="radio"/> Allergies	
<input type="radio"/> Immunity	



# CASSIDY'S CAUSE: AUTHORIZATION FOR

# Emergency Medical Treatment

6075 Clinton Road · Paducah, KY 42001 · 270.554.4040 · 270.554.0023 Fax

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

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

Home Address \_\_\_\_\_

\_\_\_\_\_

City

State

Zip

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

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

Health Insurance Company \_\_\_\_\_

Allergies to Medication(s) \_\_\_\_\_

Current Medication(s) \_\_\_\_\_

\_\_\_\_\_

**Person(s) to be contacted in case of an emergency**

1. Name \_\_\_\_\_

Relationship \_\_\_\_\_

Phone \_\_\_\_\_

2. Name \_\_\_\_\_

Relationship \_\_\_\_\_

Phone \_\_\_\_\_

3. Name \_\_\_\_\_

Relationship \_\_\_\_\_

Phone \_\_\_\_\_

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(PAGE 2) AUTHORIZATION FOR

# Emergency Medical Treatment

6075 Clinton Road · Paducah, KY 42001 · 270.554.4040 · 270.554.0023 Fax

**Consent for emergency medical treatment is required of all Cassidy's Cause Therapeutic Riding Academy, Inc. volunteers due to the inherent risk of injury when participating in farm animal activities.**

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services at Cassidy's Cause Therapeutic Riding Academy, Inc., or while being on the property of the agency, I authorize Cassidy's Cause Therapeutic Riding Academy, Inc., to:

1. Secure and retain medical treatment and transportation, if needed.
2. Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment.

## Consent Plan

**I do consent to emergency medical aid/treatment**

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 (s) listed above is unable to be reached.

## Non-Consent Plan

**I do NOT consent to emergency medical aid/treatment**

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services at Cassidy's Cause Therapeutic Riding Academy, Inc or while being on the property of the agency.

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Signature of participant or parent/guardian

Date \_\_\_\_\_



## CASSIDY'S CAUSE PROGRAM APPLICATION

# Liability Release 2026

6075 Clinton Road · Paducah, KY 42001 · 270.554.4040 · 270.554.0023 Fax

**PARTICIPANT NAME** \_\_\_\_\_ would like to participate in the Cassidy's Cause Therapeutic Riding Academy, Inc. (CCTRA) program. I am aware there exist significant risks from horseback riding and horse related activities, including permanent paralysis and death, and that such injuries may occur despite all reasonable precautions by myself and Cassidy's Cause, its employees and/or agents. However, I feel that the possible benefits to myself/my son/daughter/ward are greater than the risk assumed. In consideration for being allowed to participate in the activities of Cassidy's Cause, I hereby, to the fullest extent permitted by law, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, as well as those of my son/daughter/ward, waive and release forever all claims whatsoever, known or unknown, whether at law or in equity, now or in the future, against Cassidy's Cause Therapeutic Riding Academy, Inc., its Board of Directors, Employees, Instructors, Therapists, Aides, Volunteers, Equines, Equine Owners, Equipment, and Operating Site for any and all injuries and/or losses of whatever nature or description, including disability or death, I/my son/daughter/ward may sustain while participating at CCTRA. By execution of this release, I represent that I have the legal authority to bind myself and my son/daughter/ward.

**WARNING: Under Kentucky law, a farm animal activity sponsor, farm animal professional, or other person does not have a duty to eliminate all risks of injury of participation in farm animal activities. There are inherent risks of injury that you voluntarily accept if you participate in farm animal activities.**

\_\_\_\_\_  
Signature of participant or parent/guardian

Date \_\_\_\_\_

## Participant Media Release

**I DO**  **I DO NOT** consent to and authorize the use and reproduction by Cassidy's Cause Therapeutic Academy, Inc. of any and all photographs and any other audio-visual materials taken of me for promotional material, educational activities, exhibits, electronic publications (including World Wide Web), or for any other use for the benefit of the program.

\_\_\_\_\_  
Signature of participant or parent/guardian

Date \_\_\_\_\_



# CASSIDY'S CAUSE THERAPEUTIC RIDING ACADEMY

## Participant Program Application • Medical Records Request

6075 Clinton Road · Paducah, KY 42001 · cassidyscause.org  
Office 270.554.4040 · Fax 270.554.0023

### *Consent for Release of Participant's Information*

I hereby authorize \_\_\_\_\_  
Medical Office or School

To release information from the records of

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

The information is to be released to Cassidy's Cause Therapeutic Riding Academy, Inc. for the purpose of developing an equine activity program for the above name participant.

The information to be released is indicated below:

- Medical History
- Physical therapy evaluation, assessment, and program plan
- Speech therapy evaluation, assessment, and program plan
- Mental health diagnosis and treatment plan
- Individual Habilitation Plan (IHP)
- Classroom Individual Education Plan (IEP)
- Psychosocial evaluation, assessment and program plan
- Cognitive-behavioral management plan
- Other \_\_\_\_\_

This release is valid for one year and can be revoked, in writing, at my request.

\_\_\_\_\_  
Signature of participant or parent/guardian

Date \_\_\_\_\_

Print Name \_\_\_\_\_

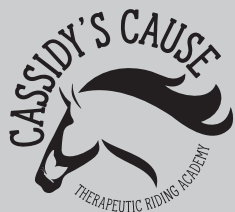
Relation to Participant \_\_\_\_\_

Please send material to:

**BY MAIL**  
Cassidy's Cause  
6075 Clinton Rd  
Paducah, KY 42001

**BY FAX**  
270.554.0023

**BY EMAIL**  
dara@cassidyscause.org



# CASSIDY'S CAUSE THERAPEUTIC RIDING ACADEMY

## Participant Program Application • Medical Records Request

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### *Health Care Provider Instructions*

Date \_\_\_\_\_

Dear Health Care Provider,

Your patient, NAME \_\_\_\_\_,  
is interested in participating in supervised equine activities at Cassidy's Cause TRA.

In order to safely provide this service, our center requests that you complete/update the attached **Medical History** and **Physician's Statement** forms. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

MEDICAL /PSYCHOLOGICAL	ORTHOPEDIC
<input type="checkbox"/> Allergies	<input type="checkbox"/> Atlantoaxial Instability – include neurologic systems
<input type="checkbox"/> Abuse, to Animals	<input type="checkbox"/> Coxarthrosis
<input type="checkbox"/> Abuse, received Physical/Sexual/Emotional	<input type="checkbox"/> Cranial Defects
<input type="checkbox"/> Blood Pressure Control	<input type="checkbox"/> Heterotopic Ossification/Myositis Ossificans
<input type="checkbox"/> Cancer	<input type="checkbox"/> Joint subluxation/dislocation
<input type="checkbox"/> Cardiac Condition	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Dangerous to Self or Others	<input type="checkbox"/> Pathologic Fractures
<input type="checkbox"/> Exacerbations of Medical conditions (RA, MS)	<input type="checkbox"/> Spinal Joint Fusion/Fixation
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Spinal Joint Instability/Abnormalities
<input type="checkbox"/> Impulse Control	NEUROLOGICAL
<input type="checkbox"/> Medical Instability	<input type="checkbox"/> Hydrocephalus/Shunt
<input type="checkbox"/> Migraines	<input type="checkbox"/> Seizure
<input type="checkbox"/> Peripheral Vascular Disease (PVD)	<input type="checkbox"/> Spina Bifida/Chiari II Malformation/Hydromyelia
<input type="checkbox"/> Pyromania	OTHER
<input type="checkbox"/> Respiratory Compromise	<input type="checkbox"/> Age – under 4 years
<input type="checkbox"/> Recent Surgeries	<input type="checkbox"/> Indwelling Catheters/Medical Equipment
<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Medications – e.g., Photosensitivity
<input type="checkbox"/> Thought Control Disorders	<input type="checkbox"/> Poor Endurance
<input type="checkbox"/> Weight Control Disorder	<input type="checkbox"/> Skin Breakdown

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,  
Angie Jackson, Executive Director  
Cassidy's Cause Therapeutic Riding Academy



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## Participant Program Application • Medical Records Request

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### Health Care Provider: Participant Medical History

Participant's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

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

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

Medications \_\_\_\_\_

Seizure Type \_\_\_\_\_  Not Applicable

Controlled?  Yes  No Date of last seizure? \_\_\_\_\_

Shunt Present?  Yes  No Date of last revision \_\_\_\_\_

Mobility Type  Independent Ambulation  Assisted Ambulation  Wheelchair

Assistive Devices \_\_\_\_\_

**For those with Down Syndrome:** Neurological Symptoms of Atlantoaxial Instability?  Present  Absent

**Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.**

	Yes	No	Comments
Vision			
Hearing/Auditory			
Tactile Sensation			
Communication			
Heart/Cardiac			
Breathing			
Digestion			
Elimination			
Circulation			
Pain			
Bone/Joint			
Muscular			

	Yes	No	Comments
Mobility			
Balance			
Thinking/Cognition			
Learning Disability			
Emotional Control			
Mental Health			
Attention Span			
Behavioral			
Self-Harm			
Allergies			
Immunity			



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### *Health Care Provider: Physician's Statement*

To my knowledge there is no reason why this person cannot participate in supervised equine activities. I understand that Cassidy's Cause Therapeutic Riding Academy, Inc. will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Cassidy's Cause for ongoing evaluation to determine eligibility for participation.

Provider's Name \_\_\_\_\_

Title  MD  DO  NP  PA  Other \_\_\_\_\_

License/UPIN # \_\_\_\_\_

Practice Name \_\_\_\_\_

Practice Address \_\_\_\_\_

City

State

Zip

Practice Phone \_\_\_\_\_

\_\_\_\_\_  
Signature of Health Care Provider

Today's Date \_\_\_\_\_