



JH | JACKSON HOLE
TR | THERAPEUTIC
RIDING

JACKSON HOLE THERAPEUTIC RIDING

Annual Participant Application

PLEASE RETURN TO: program@jhtr.org | Fax: 307.732.0212 | PO Box 415 Teton Village, WY 83025

Participant Name: _____ DOB: _____

Gender: _____ Pronouns: _____ Height: _____ Weight*: _____

**For the safety of our riders, volunteers, and equine partners, JHTR maintains a 200-pound maximum rider weight limit. This policy is in place to ensure we can safely perform emergency dismounts if needed and to protect the wellbeing of both participants and horses.*

Mailing Address: _____

Parent/Legal Guardian(s): _____

Phone: _____ Email: _____

Additional Caregivers: _____

What is the best way for us to get in touch with you on short notice? Email Text Call
(e.g. in the event of a lesson cancellation)

Employer/School: _____

How did you hear about this program? _____

Have you participated with JHTR in the past? Yes No If so, when did you begin? _____

What program are you interested in?

Adaptive Riding

Equine Facilitated Learning

Occupational Therapy

Making Memories

Veteran Equine Therapy

I'm unsure. Please contact me to discuss options.

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MEDICAL HISTORY & NEEDS

Diagnosis/Concerns: _____

Allergies: _____

CURRENT MEDICATIONS

Please include prescription and over-the-counter, name, dose and frequency.

Name	Dosage	Frequency

HISTORY OF SEIZURES? Yes No

If yes, describe seizure type, frequency, and typical triggers:

MOBILITY/ASSISTIVE DEVICES USED:

None Cane Walker Wheelchair Crutches Prosthesis Braces

PLEASE INDICATE CURRENT OR PAST SPECIAL NEEDS IN THE FOLLOWING AREAS:

Category	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion/Elimination			
Circulation			
Emotional/Mental/Behavioral			
Pain			
Bone/Joint/Muscular			
Thinking/Cognition			

EMERGENCY CONTACT INFORMATION

Please provide the information for the primary and secondary emergency contacts we should call if there is a medical or other emergency.

PRIMARY EMERGENCY CONTACT NAME: _____

Phone: _____ Relation: _____

SECONDARY EMERGENCY CONTACT NAME: _____

Phone: _____ Relation: _____

Primary Care Physician/Medical Provider: _____ Phone: _____

I authorize Jackson Hole Therapeutic Riding to seek emergency medical treatment for the participant if I cannot be reached. This authorizes staff to act in the participant's best interest in case of emergency.

Signature: _____ Date: _____

*If participant is under 18, a parent or legal guardian must sign.
By signing you confirm that you agree to the release above.*

PHYSICAL FUNCTION

Please describe abilities/difficulties, including assistance required or equipment needed (e.g. mobility skills such as transfers, walking, wheelchair use, driving, etc).

PSYCHOSOCIAL FUNCTION

Please describe abilities/difficulties, including assistance required or equipment needed (i.e. work/school including grade completed, leisure interests, relationships, family structure, support systems, companion animals, fears, etc).

RIDING / HORSEMANSHIP EXPERIENCE

Select the option that best describes the participant's experience with horses and riding.

No experience

Some experience

Regular rider/experienced

If applicable, describe riding experience or previous therapeutic riding. Provide details about lessons, riding skills, or therapeutic riding history.

PARTICIPANT GOALS

Describe goals (physical, cognitive, emotional, social) you hope to achieve through participation. Be specific if possible.

ASSUMPTION OF RISK & LIABILITY RELEASE

UNDER WYOMING LAW, AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES, PURSUANT TO W.S. § 1-1-123

Participating at Jackson Hole Therapeutic Riding involves activities with horses which are inherently risky and may result in injury. The undersigned hereby, intending to be legally bound, acknowledges they understand these risks, consent to participation, and release Jackson Hole Therapeutic Riding, its staff, volunteers, and board of directors from liability for any and all injuries and/or losses arising from participation except in cases of willful misconduct. If you do not understand any part of this release, contact us prior to signing.

I have read, understand, and agree to the Assumption of Risk & Release above.

Signature: _____ Date: _____

*If participant is under 18, a parent or legal guardian must sign.
By signing you confirm that you agree to the release above.*

JHTR POLICIES

By signing this agreement, I the Participant or Parent/Legal guardian (if under 18yrs old), agree to the following policies at JHTR:

- **Payment Policy:** Session fees or complete financial aid application are due before each session begins.
- **Participant Attendance Policy:** If a participant misses a class there will not be a refund or a make-up class scheduled. If JHTR cancels a class, there will be the choice of a make-up class or refund.
 - **Exceptional Circumstances:** JHTR may approve prearranged absences in which exemption from participation appears to be in the best interest of the participant or their family.
- I understand that the JHTR arena is located and leased on public school grounds, and I must abide by these governmental laws:
 - **NO DOGS** on premises (even contained within vehicles)
 - **NO TOBACCO PRODUCTS** on premises
 - **NO DRUGS/ALCOHOL** allowed on premises or to be used prior to volunteering
 - **NO GUNS/WEAPONS** on premises
 - **10 MPH** when driving on premises (be alert and cautious, children at play)

Signature: _____ Date: _____

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MEDIA RELEASE

Jackson Hole Therapeutic Riding (JHTR) uses photographs, video recordings, and participant stories to share the impact of our programs and advance our mission.

I grant permission to Jackson Hole Therapeutic Riding (JHTR) to photograph, film, and/or otherwise document myself and/or the participant named below while participating in JHTR programs, events, or activities.

I authorize JHTR to use these images, recordings, and any written or verbal statements, testimonials, or feedback related to participation in the program for purposes including, but not limited to:

- Educational and training materials
- Program promotion and marketing
- Publications and newsletters
- Grant applications and reports
- Website and social media content
- Other communications that support and promote the mission of JHTR

I UNDERSTAND AND AGREE THAT:

- These materials may appear in print, digital, or electronic formats.
- JHTR may use these materials without compensation or additional approval.
- JHTR will not sell or distribute these materials for commercial purposes.

This authorization will remain in effect unless revoked in writing. Any revocation will apply only to future uses and cannot apply to materials that have already been published or distributed.

DO YOU AGREE WITH THESE TERMS?

Yes, I consent

No, I do not consent

Signature: _____ Date: _____

*If participant is under 18, a parent or legal guardian must sign.
By signing you confirm that you agree to the release above.*

PARTICIPANT'S CONSENT FOR RELEASE OF INFORMATION

I hereby authorize _____ to release
Doctor or medical facility
information from the records of _____.
Participant's name

The information is to be released to Jackson Hole Therapeutic Riding for the purpose of developing an equine activity program for the above-named participant. The information to be released is indicated below:

Choice

Medical history

Physical therapy evaluation, assessment and program plan

Occupational 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

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

I HAVE RECEIVED, READ, AND AGREED TO THE TERMS LISTED ABOVE.

Print Name: _____ Relation to Participant: _____

Signature: _____ Date: _____

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By signing you confirm that you agree to the release above.*

PERMISSION TO DISCLOSE PARTICIPANT INFORMATION

In accordance with the HIPAA law, Jackson Hole Therapeutic Riding is asking for the names and contact information of additional relatives or friends who may be involved in your/your child's care or in the payment for your/your child's services at JHTR.

By giving us this information, you are granting us permission to discuss progress notes, any billing matters, or other issues of concern which may arise while at JHTR with these individuals.

PARTICIPANT NAME: _____

Other relatives or friends who are involved in the participant's care:

Print Name: _____ Relation to Participant: _____

Phone: _____ Email: _____

Print Name: _____ Relation to Participant: _____

Phone: _____ Email: _____

I HAVE RECEIVED, READ, AND AGREED TO THE TERMS LISTED ABOVE.

Signature: _____ Date: _____

*If participant is under 18, a parent or legal guardian must sign.
By signing you confirm that you agree to the release above.*

BILLING POLICY

Participants are assigned to lessons on a session basis. A session consists of 3-6 weeks. Participants are billed by JHTR prior to the start of a new session. Participants are given a billing information sheet, as well as a cancellation policy as part of the participant packet. This form must be signed and turned in as part of the participant file.

Providing an email address allows JHTR to send statements electronically. Participants may view and securely pay their invoice online by credit card. Payment may also be made by check or cash.

If payment for the previous session has not been received, the participant will be ineligible to enroll in the following session. Payment plans are available, please contact the Executive Director to discuss your options.

Financial aid is available if the participant qualifies. Please refer to financial aid policy.

JHTR does not bill insurance companies or third parties for equine activities. If you are receiving Occupational Therapy services, insurance will be billed via the contract therapist upon request depending on the individuals provider and policy.

I HAVE RECEIVED, READ, AND AGREED TO THE TERMS LISTED ABOVE.

Signature: _____ Date: _____

*If participant is under 18, a parent or legal guardian must sign.
By signing you confirm that you agree to the release above.*

BILLING INFORMATION SHEET

Participant's Name:	
Bill to (Full Name):	
Billing Address:	
City, State, Zip:	
Phone:	
Email*:	

2026 SESSION DATES & FEES

Session	Dates	Adaptive Riding	Occupational Therapy
Spring*	May 4 th – June 5 th	\$225*	\$500*
Summer	June 29 th – July 31 st	\$225	\$500
Fall	September 14 th – October 9 th	\$180	\$400

**There will be no classes on Monday, May 25th in honor of Memorial Day and fees will be altered accordingly.*

CANCELLATION POLICY

Horses are very expensive to maintain, and we depend on income from our lessons to keep the program going! In order to effectively manage paid staff and volunteer hours, JHTR must enforce the following cancellation policy:

- A credit will only be given when JHTR cancels a lesson.
- No participant will be allowed to start a new session if they have a past due balance from the previous session. Anyone who has a past due balance should contact the Executive Director to make payment arrangements. Any rider who has not made payment arrangements from a past due bill will not be allowed to participate.
- If a participant misses two (2) lessons without notifying JHTR, they may be removed from the schedule for the remainder of that session. The participant may apply to re-enter the program for the following session.

I understand I will be billed for any services provided to the above participant(s) and I agree to pay for these services or submit a Financial Aid Application.

Signature: _____ Date: _____

*Providing an email address allows JHTR to send you statements electronically. Your email address will be used solely to facilitate electronic billing and communications with JHTR. You will be able to view and pay your statement online by credit card at the website indicated on the statement. You will also be able to pay by mailing a check or providing cash/check to the JHTR staff.