



## **2026 HHTR Dates**

**Spring - May 19- June 23**

**Summer – TBA**

**Fall – TBA**

**PLEASE NOTE:** Our new location is 3 miles south of Bowman just off Highway 85. Our new address is: **8904 146<sup>th</sup> Ave SW, Bowman, ND.**

We will work with you as much as possible to set up the time slot that works best for you and your family. With limited time slots, we cannot guarantee your preferred time slot will be available.

HHTR & HPR sessions are **\$350.**

- Please read over the policies and fill out the application form. Please have applications/ Physicians' statements returned to Hope and Healing TR **one week** prior to the first lesson.
- There is a section that needs to be completed by the **client's physician** prior to participating **ONLY** if the client has a disability that could be a contraindication to riding in equine assisted activities.
- **Return completed forms to:** Hope and Healing Therapeutic Riding  
PO Box 185, Bowman, ND 58623  
OR  
[hopehealingtr@outlook.com](mailto:hopehealingtr@outlook.com)

Contact Robyn at (701) 523-6407 with any questions/concerns!

I have read and understand the above policies/the attached policy sheet  
Signature \_\_\_\_\_



## Rider Registration Form

**Name of Rider:** \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Parent/Guardian/ Caregiver name:** \_\_\_\_\_

Phone (H): \_\_\_\_\_ Phone (C): \_\_\_\_\_

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

**Name of Payee:** \_\_\_\_\_

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

Phone (H): \_\_\_\_\_ Phone (C): \_\_\_\_\_

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

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

Does the rider have any previous horse experience? Please explain: \_\_\_\_\_  
\_\_\_\_\_

**T-shirt size** \_\_\_\_\_



## Rider information and Health History

**Diagnosis:**

Primary \_\_\_\_\_ Secondary \_\_\_\_\_

Date of Onset \_\_\_\_\_.

What medications are you currently taking, including over-the-counter medications?

\_\_\_\_\_

**Please indicate past or current special needs in the following areas**

	YES	NO	COMMENTS
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Thinking/Cognitive			
Allergies			<b>Epi Pen? Y N</b>

It is the responsibility of the rider/guardian/caregiver to notify the facility immediately when changes in medical status or contact information occur.

Payment for each session is due in full by the 1<sup>st</sup> class of that session unless prior arrangements have been made.

**Account must be current before signing up for the next session.**



**Physical Skills:**

Mark an X for the following skills the participant is NOT independent in.

Sits unassisted	Uses hands independently	Uses bathroom Independently
Stands Independently	Releases objects	Climbs stairs
Walks unassisted	Bears weight on hands	Bears weight on legs
Runs unassisted	Grasps small objects	Standing balance

Please list any assistive devices that the participant may use at home or school:

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**Cognitive and processing:**

\_\_\_ No concerns (if there are no concerns in any of the following areas, please skip ahead to the Personality Profile)

If there are concerns in the area of cognition and processing, please complete the following:

Mark an X for the following skills the participant is NOT independent in.

<b>Educational/Cognitive</b>	<b>Social</b>	<b>Language</b>
• Knows Numbers	• Recognizes name	• Makes sounds
• Knows letters	• Makes eye contact	• Says words
• Knows right/left	• Waves/says hello/bye	• Combines 2 or more words
• Knows prepositions	• Shares toys/items	• Speaks in complete sentences
• Communicates feelings	• Knows safety awareness	• Understands “no”
• Makes Choices	• Interacts with others	• Letter sound identification

Follows directions: 1 step\_\_\_ 2 step\_\_\_ 3 step\_\_\_ Complex\_\_\_

Attention to task: Poor (0-1 min)\_\_\_ Fair (1-5min)\_\_\_ Average (5+ min)\_\_\_

Frustration Tolerance: Poor\_\_\_ Fair\_\_\_ Avg\_\_\_

Problem Solving: Poor\_\_\_ Fair\_\_\_ Avg\_\_\_



**Personality profile**

Describe rider's personality

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What are some favorite activities or topics? \_\_\_\_\_

What are some fears or dislikes? \_\_\_\_\_

Any psychological, emotional, behavioral or social issues not already addressed: \_\_\_\_\_

Successful intervention strategies used (sensory modalities, behavioral, rewards etc) \_\_\_\_\_

Our Family's Do's and Don'ts

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Any other special things we should know? \_\_\_\_\_

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Please list any goals (i.e. what would you like to accomplish in therapeutic riding)

**Participant's goals:**

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**Parent/Family goals:**

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## Participant Authorization for Emergency Medical Treatment Form

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

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

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

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

**Allergies (include medications):**

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

In the event of an emergency, contact:

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

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

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

In the event emergency medical aid/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 HOPE AND HEALING THERAPEUTIC RIDING 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 emergency treatment.

**\*\*Please Choose ONE\*\***

**Consent Plan**

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) above is unable to be reached.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_  
Volunteer, 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 Hope and Healing Program activities.

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

\_\_\_\_\_

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

Consent Signature: \_\_\_\_\_  
Volunteer, Parent or Legal Guardian



## Hope and Healing Therapeutic Riding Permission to Photograph

### PHOTO RELEASE:

**DO** **DO NOT** consent to and authorize the use and reproduction by HOPE AND HEALING THERAPEUTIC RIDING any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program (this includes the website and social media).

**PHOTOS/VIDEOS you take at Hope and Healing Therapeutic Riding of riders/volunteers other than YOUR child/family member may NOT be posted to Facebook or any other social media sites. Please respect the privacy of all participants and volunteers.**

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

Client, Parent or Legal Guardian

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



**Assumption of Risk and Liability Release**

THIS DOCUMENT LIMITS YOUR RIGHT TO RECOVERY OF DAMAGES IN CASE OF BODILY INJURY OR PROPERTY DAMAGE. READ IT CAREFULLY BEFORE SIGNING. THROUGH PARTICIPATION IN THIS ACTIVITY, YOU ARE EXPOSING YOURSELF, YOUR PROPERTY AND OTHERS TO A SUBSTANTIAL AND SERIOUS RISK OF PROPERTY DAMAGE, PERSONAL INJURY, OR DEATH.

**ASSUMPTION OF RISK.** In consideration of my being allowed to participate in equine activities with HOPE AND HEALING THERAPEUTIC RIDING, I assume all risks and responsibilities for the safety of myself, my animals, and my property, as well as the safety of the person, animals, and any property of any minor who accompanies me.

**LIABILITY RELEASE.** I agree that in consideration of HOPE AND HEALING THERAPEUTIC RIDING allowing my participation in this activity, I, the rider, do agree to hold harmless, release, and discharge HOPE AND HEALING THERAPEUTIC RIDING, its owners, agents, employees, officers, directors, representatives, assigns, members, owners of premises and trials, affiliated organizations, insurers, and others acting on its behalf (hereinafter collectively referred to as "ASSOCIATES"), of and from all claims, demands, causes of action and legal liability, whether the same be known or unknown, anticipated or unanticipated, due to HOPE AND HEALING THERAPEUTIC RIDING and/or its ASSOCIATES ordinary negligence; and I do further agree that except in the event of HOPE AND HEALING THERAPEUTIC RIDING gross negligence and willful and wanton misconduct, I shall not bring any claims, demands, legal actions and causes of action, against HOPE AND HEALING THERAPEUTIC RIDING and its ASSOCIATES as stated above in this clause, for any economic and non-economic losses due to bodily injury, death, property damage, sustained by me and/or my minor child and/or legal ward in relation to the premises and operations of HOPE AND HEALING THERAPEUTIC RIDING, to include while riding, handling, or otherwise being near horses owned by or in the care, custody and control of HOPE AND HEALING THERAPEUTIC RIDING, whether on or off the premises of HOPE AND HEALING THERAPEUTIC RIDING.

I hereby warrant and represent that I am of lawful age and legally competent to sign this RELEASE; that I understand that the terms of this RELEASE are contractual; and the RELEASE shall be binding on my personal representative or estate, assigns, heirs and next of kin and that I have signed this RELEASE as my own free act. I hereby state that if any part of the RELEASE is found not to be legally binding on me, all other parts of the RELEASE shall be binding on me and continue in full force and effect. I further warrant and represent that I shall comply with all policies and obey all rules and regulations of HOPE AND HEALING THERAPEUTIC RIDING agents included those outlined herein.

**WARNING. Under North Dakota law, an equine sponsor or 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.**

**CAUTION: THIS IS A RELEASE! I HAVE FULLY INFORMED MYSELF OF THE CONTENTS OF THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK BY CAREFULLY READING IT BEFORE SIGNING IT.**

\_\_\_\_\_ Applicant's Name

\_\_\_\_\_ Applicant's Signature

{Parent or legal guardian if under 18}

Date\_\_\_\_\_.

\_\_\_\_\_ Witness



## 2026 RELEASE AND AGREEMENT

1. I, \_\_\_\_\_, the undersigned or my minor child, (herein called Releasor), in consideration of being permitted to use the facilities and services of Hope and Healing Therapeutic Riding for himself/herself, spouse, my minor child, legal representatives, heirs and assigns, HEREBY RELEASES, WAIVES AND DISCHARGES HOPE AND HEALING THERAPEUTIC RIDING, (HEREIN CALLED RELEASEE) THE OWNERS AND LESSEES OF HOPE AND HEALING THERAPEUTIC RIDING, THEIR AGENTS, EMPLOYEES AND VOLUNTEERS, FROM ALL LIABILITY TO THE RELEASOR, THEIR SPOUSE, LEGAL REPRESENTATIVES, HEIRS AND ASSIGNS, FOR ANY AND ALL LOSS OR DAMAGE, AND ANY CLAIM OR DAMAGES RESULTING THEREFROM ON ACCOUNT OF INJURY TO RELEASOR'S PERSON, EVEN INJURY RESULTING IN DEATH OF THE RELEASOR, WHETHER CAUSED BY THE NEGLIGENCE OF RELEASOR OR OTHERWISE WHILE THE RELEASOR IS RIDING, WORKING, OR FOR ANY PURPOSE USING THE FACILITIES, EQUIPMENT OR SERVICES OF HOPE AND HEALING THERAPEUTIC RIDING.

2. I agree to indemnify Hope and Healing Therapeutic Riding, from any loss, damage or cost they may incur due to the participation or use of the facilities, equipment and services of Releasee due to the presence of myself or my minor child in or upon the property owned, located at or controlled by Hope and Healing Therapeutic Riding caused by the negligence of the Releasees or otherwise.

3. I fully understand any involvement with horses involves some risk of harm or injury to myself, my minor child, my horses or my other property and that risk of damage or injury is a normal incident of involvement with horse related activities and I hereby agree that risk is borne by me an/or my minor child and not by Hope and Healing Therapeutic Riding or their officers, members, agents, employees or volunteers.

THIS RELEASE CONTAINS THE ENTIRE AGREEMENT BETWEEN THE PARTIES HERETO AND THE TERMS OF THIS RELEASE ARE CONTRACTUAL AND NOT A MERE RECITAL.

I HAVE CAREFULLY READ THE FOREGOING RELEASE AND KNOW THE CONTENTS THEREOF AND SIGNED THIS RELEASE AS MY OWN FREE ACT.

Releasor (Parent/Guardian) \_\_\_\_\_

Minor Child \_\_\_\_\_

Date \_\_\_\_\_