



Riding for the Disabled Association is a not for profit organisation providing a range of equestrian activities for people of all ages with a disability.

This document comprises the following;

INFORMATION SHEET	- about the consent form (Pages 1 & 2 to be kept for reference by client and/or guardian)
SECTION A – PARTICIPANT INFORMATION	- for Parent, Guardian or Rider over 18
SECTION B – MEDICAL FORM	- for your usual Medical Practitioner
SECTION C	- applicable to riders with Down Syndrome
SECTION D	- applicable to riders with Spinal Fusion
SECTION E – MEDICAL REVIEW FORM	- for conditions which have changed and are not stable

INFORMATION ON RDA MEDICAL CONSENT FORM

All potential participants, or their responsible parent, guardian, or legal advocate must have read, understood and signed Section A, the Consent Form. The applicant's usual Medical Practitioner must complete Section B, the Medical Form.

RDA has a duty of care to all participants and as part of that duty each participant must complete a Medical Form as part of the registration process.

The primary purpose of the Medical Form is to have a medical practitioner verify that the participant does not have any condition which is a contra-indication for equestrian activities. For applicants with Down Syndrome, Section C must be also completed, and for applicants with Spinal fusion, Section D must be completed by the Medical Practitioner. The information provides the basis for the RDA coach to develop the most appropriate and suitable activities for each participant given their presenting condition.

In order to complete the rider registration process the name and address of the participant and summarised information as listed on the Rider Registration Form, is forwarded to State & National Offices for annual survey purposes, but the information is not used for any other purpose.

The Medical Form:

- Is a confidential document which is held in secure conditions by the RDA Centre.
- Must be completed fully by the applicant's registered Medical Practitioner
- Once the participant's application is processed, the information contained in the Form is stored securely, and is accessible only to the RDA Coaches and Administrators at the centre for the purposes of developing the rider's program and reviewing progress.
- Will not be used for any other purpose.
- Is accessible to the participant, parent /guardian at their request.
- For any condition which is not stable and may improve or degenerate over time, the medical review must be completed as specified.

**RETAIN THIS SHEET FOR YOUR INFORMATION AFTER
THE FORM HAS BEEN COMPLETED BY A MEDICAL PRACTITIONER**



CONTRAINDICATIONS FOR RIDING WITH RDA

Conditions for which clients **MUST NOT** ride:

- Pathological fractures
- Severe osteoporosis
- Uncontrolled seizures
- Acute stage rheumatoid arthritis
- Open pressure sores, open wounds
- Unstable spine, including subluxation of cervical spine
- Moderate agitation with severe confusion
- Disruptive or unreliable behaviour which is unacceptable to the Coach and other participants in the group
- Atlanto-Axial Dislocation (ADV) or significant subluxation in Down Syndrome
- Advanced multiple sclerosis and muscular dystrophy
- Haemophilia
- Acute herniated disc
- Degeneration of the hip joint
- Excessive weight; obesity

Conditions for which horse riding **MAY NOT** be recommended:

- Very poor endurance
- Excessive pain resulting from riding
- Excessive structural scoliosis, until permission is given by an orthopaedic surgeon
- Significant allergies to horse hair, dust, grain, grass, hay; hay fever
- Recent surgery until permission is given by surgeon
- Serious heart condition
- Dislocation or dysplasia of hip if excessive pain is caused
- Drug dosage resulting in physical states inappropriate to the riding environment
- Paralysis of the gluteal muscles and abdominal muscles
- High level of spinal cord paralysis or significant asymmetry of muscle paralysis

CONTRAINDICATIONS FOR CARRIAGE DRIVING WITH RDA

Conditions for which clients **MUST NOT** participate in Carriage Driving:

- Uncontrolled seizures
- Open pressure sores, open wounds
- Moderate agitation with severe confusion
- Excessive pain resulting from carriage driving
- Disruptive or unreliable behaviour which is unacceptable to the Whip and other participants in the group

Conditions for which Carriage Driving **MAY NOT** be recommended:

- Significant allergies to horse hair, dust, grain, grass, hay; hay fever
- Recent surgery until permission is given by surgeon
- Drug dosage resulting in physical states inappropriate to the carriage driving environment
- Excessive weight; obesity
- Profound intellectual disability

**RETAIN THIS SHEET FOR YOUR INFORMATION AFTER
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Issued by Riding for the Disabled Association SA Inc (RDA SA)

215 Portrush Road, Maylands SA 5069 Ph 08 8331 1833 Fax 08 8331 1188 Email admin@rdasa.org.au



MEDICAL CONSENT FORM

NOTE:

- 1. The completed Consent Form, **Section A**, must be attached to the completed Medical Form, **Section B**, and returned to the Coaching Coordinator at the RDA Centre in order for your application to be processed.

The Coaching Coordinator, RDA CENTRE.....

- 2. Please be aware that some centres have a waiting list and there may be a time delay between completing these forms and commencing participation.

SECTION A

PARTICIPANT INFORMATION

Name of Participant Date of Birth

Address

..... P'Code Telephone

Height Weight Male/Female.....

Nature of Disability

Age of onset of disability

Any other relevant information

.....

Member of the Ambulance Service: Yes / No Membership No

I have read and fully understood the content of this Information Sheet

Signature Date

Self if over 18 and able to sign/Parent/ Guardian / Legal Advocate (Please circle)

EMERGENCY CONTACT INFORMATION

NAME:

ADDRESS:

.....

TELEPHONE: Home Work

Mobile.....

Relationship to participant

Please complete & copy both sides



MEDICAL CONSENT FORM

SECTION B

MEDICAL FORM

Please use block letters

Name of participant Date of Birth

Name of Medical Practitioner

Address

Telephone No Email

Diagnosis

Brief History (if applicable)

.....

Does the participant have: please answer ALL

Medication	Yes/No	Heart Problems	Yes/No
Epileptic fits	Yes/No	Drainage Devices	Yes/No
Fainting Turns	Yes/No	Paralysis	Yes/No
Postural Hypotension	Yes/No	Flaccidity	Yes/No
Hypertension	Yes/No	Allergies	Yes/No
Impaired Hearing	Yes/No	Muscle overactivity	Yes/No
Impaired Sight	Yes/No	Inflammation or pain in the joints	Yes/No
Impaired Speech	Yes/No	Impaired Sensation	Yes/No
Impaired Balance	Yes/No	Impaired Bladder/ Bowel control	Yes/No
Impaired Circulation	Yes/No	Use of any Splints/ Braces	Yes/No
Asthma	Yes/No	Use of any Corsets/Prostheses	Yes/No
Cranial Shunt	Yes/No	Is the participant a carrier of any infectious disease	
Diabetes	Yes/No		Yes/No
Scoliosis	Yes/No	Skin Problems	Yes/No
Intellectual Disability	Yes/No	Chronic Airways	Yes/No
Developmental Delay	Yes/No	Specific Learning Difficulty	Yes/No

Down Syndrome Yes/No

If YES, SECTION C, must be completed as further medical information is required BEFORE we can consider this applicant.

Spinal Fusion and/or External Spinal Braces Yes/No

If YES, SECTION D, must be completed as further medical information is required BEFORE we can consider this applicant.

Level of support required HIGH MED LOW

Initials of Medical Practitioner: Date:

Please complete & copy both sides



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MEDICAL CONSENT FORM

SECTION B

MEDICAL FORM CONTINUED

Name of participant Date of Birth

Please provide FULL details of any YES answers above:

.....
.....
.....
.....
.....

If relevant, please outline any other medical condition or information which may affect the participant’s response to exercise and relevant precautions to be taken, or any particular types of leisure activities from which the participant should be excluded for health reasons.

.....
.....
.....
.....
.....

If applicable, please provide details of participant’s asthma/allergy management plan (if such information is not disclosed the participant will only receive standard first aid)

.....
.....
.....
.....

Do you feel that future reviews of participant’s medical condition are advisable? Yes/No

If yes, please nominate how often

Over and above the normal risks of such activities, it seems reasonable, in my opinion, for the above named person to take part as an active participant in RDA activities. In this regard, I understand that a RDA Coach or other appropriate person(s) associated with RDA, will assess the suitability of activities based on the medical advice given above.

Name of the Medical Practitioner (BLOCK LETTERS PLEASE):

Provider number:

Telephone: Mobile no:

Signature of Medical Practitioner: Date:

Completed Sections A & B to be returned to the RDA Centre indicated on Page 2 of this document

Section C and Section D to be returned if applicable

THANK YOU



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MEDICAL CONSENT FORM

SECTION C

ADDITIONAL INFORMATION FOR APPLICANTS WITH DOWN SYNDROME

TO BE COMPLETED BY MEDICAL PRACTITIONER

RDA Policy requires that riders with Down Syndrome have a Medical Practitioner, who is aware of the possibility of Atlanto Axial Instability in people with Down Syndrome, complete this form, as well as the general Medical Form (Section B).

To minimise risks to our riders, we ask that both the parent/caregiver and the Medical Practitioner read the attached information & confirm below:

Name of participant **Date of birth**

Over and above the normal risks of such activities, it seems reasonable, in my opinion, for the above named person to take part as an active participant in RDA activities

Yes / No

Do you feel that an annual medical review of the client is necessary?

Yes / No

Name of the Medical Practitioner (BLOCK LETTERS PLEASE):

Provider number:

Telephone: Mobile no:

Signature of Medical Practitioner: Date:

Name of Parent/Guardian/Consenting Rider over 18:

Signed: Date:

Relation to rider (if not a consenting rider of 18 years):

Complete Sections A & B to be returned to the RDA Centre indicated on Page 2 of this document

Section C and Section D to be returned if applicable

THANK YOU



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MEDICAL CONSENT FORM

SECTION D

ADDITIONAL INFORMATION FOR APPLICANTS WITH SPINAL FUSION

TO BE COMPLETED BY AN ORTHOPAEDIC SPECIALIST

RDA Policy requires that riders with a Spinal Fusion (eg Harrington or CD Rods) and/or those wearing external spinal braces/orthotics must be examined by an Orthopaedic Specialist **prior** to the commencement of a riding program.

Name of participant **Date of birth**

Over and above the normal risks of such activities, it seems reasonable, in my opinion, for the above named person to take part as an active participant in RDA activities **Yes/No**

Further comments where necessary:

.....
.....
.....
.....

Name of the Orthopaedic Specialist (BLOCK LETTERS PLEASE):.....

Provider number:

Telephone: Mobile no:

Signature of Orthopaedic Specialist: Date:

Name of Parent/Guardian/Consenting Rider over 18:.....

Signed: Date:

Relation to rider (if not a consenting rider of 18 years):.....

Complete Sections A & B to be returned to the RDA Centre indicated on Page 2 of this document

Section C and Section D to be returned if applicable

THANK YOU





SECTION E

MEDICAL CONSENT REVIEW FORM

This form should be accompanied by a copy of the 'Participant Information' (Section A)

This MEDICAL CONSENT REVIEW FORM is to be completed by a medical practitioner where a participant has a condition which may deteriorate or improve over time as per medical recommendation. This form must be attached to the client's original MEDICAL CONSENT FORM.

RDA Coaches may need further information about a rider/driver's medical condition in addition to the information given on this form. RDA reserves the right to refuse a person access to the program if it is reasonably believed that participation may be detrimental to the participant, the voluntary coaches and helpers and/or the horses.

I agree to the release of information about the participant's medical condition on the understanding that such information will be used only to assist the rider to more fully benefit from the RDA program.

Name of Participant Date of Birth

Address

..... P'Code Telephone

Height Weight Male/Female.....

Nature of Disability

Age of onset of disability

Any other relevant information

.....

Date of completion of the original Medical Consent Form (attach copy of original)

The medical practitioner should read the original Medical Consent Form and indicate and detail on this form any significant changes in the following:

- a) Medication Yes / No.....
- b) Behaviour Disorder Yes / No.....
- c) General Physical Health Yes / No.....
- d) Recent Surgery Yes / No.....
- e) Any other information which the coach may need to know to ensure that the rider/driver's program is of maximum benefit.

Over and above the normal risks of such activities, it seems reasonable, in my opinion, for the above named person to take part as an active participant in RDA activities **Yes / No**

Name of the Medical Practitioner (BLOCK LETTERS PLEASE):

Provider number:

Telephone: Mobile no:

Signature of Medical Practitioner: Date:

