

PARTICIPANT APPLICATION FORM

Please make sure you fill in this form clearly, using BLOCK CAPITALS, and return it to the **RDA Group address** below



This section must be completed by the RDA Group, before the form is given to the applicant	
RDA Group Name	Muirfield Riding Therapy
Charity Number	CO 028674
Group Contact Name	Susan Law
Contact Address to which the completed application form should be sent	Indoor Arena West Fenton EH39 5AL
Contact Email Address	admin@muirfieldridingtherapy.org.uk
Contact Telephone Number	01620 842502

All information provided on this form will remain strictly confidential, for use by relevant RDA personnel only, in compliance with the statutory requirements of the Data Protection Act 2018. It will be used to help us to understand any specific needs you may have and to support you. We will also use this information to contact you in relation to your activities with RDA - this may include sending you important information about your involvement in your RDA Group, or any other activities you may take part in within RDA.

PART 1 – YOUR DETAILS *(details of the participant)*

First Name/s				Last Name				
What name/ nickname do you like to be known by?				Preferred Pronouns?				
Date of Birth			Sex	M / F / I identify in another way / Prefer not to say				
If you are not fluent in English, which language/s do you use on a daily basis?								
Address								
				Postcode				
Telephone				Mobile				
Email								
Do you have any previous experience of riding or carriage driving at an RDA Group?					YES		NO	
If YES, what is the RDA Group's name?								
Are you joining as part of a school, college or care centre group, or similar?					YES		NO	
If YES, what is the name of the school, college or centre?								

PART 2 – SPECIFIC INFORMATION ABOUT YOU

Please tell us about your disability or impairment and how it affects you (to help us to understand how to support you)	
Do you have any conditions that may need special attention during your RDA activities? Is there anything else about your disability or impairment that we should be aware of, to help us to improve your RDA experience?	
In case we need to find out more about your disability and how we can support you, please provide the name and contact details of a medical professional, who knows you and is familiar with your medical condition(s)	
What is your height?	What is your current weight?
<i>Please note that the applicant's height and weight details will be used discreetly by the group's coach, to assess the suitability of available horses or ponies</i>	

PART 3 – ADDITIONAL INFORMATION

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ALLERGIES	Do you have any known allergies?	YES		NO	
EYESIGHT	Do you have a visual impairment, or do you have low vision?	YES		NO	
HEARING	Do you have a hearing impairment, or do you have hearing loss?	YES		NO	
WALKING/MOBILITY	Do you need any help with walking?	YES		NO	
	Can you walk up a few steps (e.g. up a mounting block to a horse)?	YES		NO	
	Do you use any walking aids or supports?	YES		NO	
	Do you wear any orthopaedic appliances?	YES		NO	
	Are you a wheelchair user?	YES		NO	
COMMUNICATION	Can you take weight through your feet (e.g. sitting to standing)?	YES		NO	
	Do you understand BSL and use it to communicate yourself?	YES		NO	
INSTRUCTIONS	Do you understand Makaton and use it to communicate yourself?	YES		NO	
	Would you prefer that we help you by using very simple instructions?	YES		NO	
If you have answered YES to any of the above questions, please detail any additional information that you think would be helpful to us, to be able to help and support you, and give you the best experience we can					

PART 4 – DECLARATION

<ul style="list-style-type: none"> I wish to apply to join an RDA Group as a participant, and confirm that all details given on this form are true and accurate, to the best of my knowledge I agree that should the RDA Coach require additional information on my medical condition at any time, I will provide what is needed and will be willing to obtain a medical report from a medical professional, if necessary, who is familiar with my condition/s. I understand that I may be required to pay a fee for such a report. I confirm that I will notify RDA immediately if any of the details or information provided on this form should change in any way I recognise that this activity involves risk, and that I, the participant, must take all reasonable precautions and follow all advice properly given, at all times I understand that horses and ponies, by nature, are unpredictable and as such they may react to a situation or to the local environment in such a way that the rider/ vaulter/ carriage driver may be unseated by accident <p>In the absence of any negligence on the part of the RDA Group or RDA UK, I fully understand and accept that no liability will attach to either party.</p>					
PHOTOGRAPHS/ VIDEOS	I give my consent to photographs or videos of me being taken during RDA activities for training and/or publicity (including, but not limited to, websites, social media, newsletters and marketing materials for the RDA Group and RDA UK). I give this consent understanding that these images will <u>not</u> be given to a third party without my explicit consent	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
SIGNATURE PARTICIPANT / PARENT / GUARDIAN / CARER <i>(please delete as appropriate)</i>	DATE			

Emergency Contact Details	It is important that we know who to contact in case you are injured or become unwell. By ticking this box I confirm that have the consent of the person below, to be contacted in an emergency during the course of RDA activities	<input type="checkbox"/>
Emergency Contact Name & Relationship to Applicant		Emergency Contact Number

PART 5 – APPLICANT’S PARENT OR LEGAL GUARDIAN DETAILS & CONFIRMATION OF CONSENT TO JOIN RDA

(if this form has been completed by a parent/ legal guardian, or if the applicant is under 18 years old)

Name		Relationship to Applicant	
Address		Postcode	
Telephone		Mobile	

RDA GROUP USE ONLY:	DATE APPLICATION RECEIVED: _____
APPLICATION	APPROVED / DECLINED (delete as applicable)
APPLICATION SUBJECT TO TRIAL PERIOD?	Y / N If yes, trial end date: _____
APPLICATION REVIEW DUE DATE (MUST BE AT LEAST EVERY 3 YEARS):	_____

Supplementary Application Information

Name:		Date of Birth:	
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Please could you answer the following questions to enable us to keep you safe and to give you the best possible experience? If YES, please use the box overleaf to provide details, referencing the question number.

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| 1. Have you ridden a horse before? | Yes | No |
| 2. Are you likely to be very scared and need extra help? | Yes | No |
| 3. Do you tire quickly with exercise? | Yes | No |
| 4. Do you have any pain? | Yes | No |
| 5. Do you have sensory triggers?
e.g. noise, touch, sensations | Yes | No |
| 6. Do you have difficulty sitting on a chair independently?
i.e. without straps | Yes | No |
| 7. Do you have difficulty controlling your head? | Yes | No |
| 8. Do you have any problems with your back or neck? | Yes | No |
| 9. Do you have any problems with your hips? | Yes | No |
| 10. Do you have epilepsy or any type of seizures?
If yes, please complete the additional questions on reverse of form. | Yes | No |
| 11. Do you have any problems with blood clotting or bone density? | Yes | No |
| 12. Do you have any current health or medical problems which are not listed on the application form? e.g. swelling of any joint(s), autoimmune condition, open wounds, asthma, allergies, eating disorders, recent surgery, diabetes, current virus. | Yes | No |
| 13. Do you have any tubes or orthoses? | Yes | No |
| 14. Do you have problems with sensation?
For Example: would you feel pain, and be able to tell us, if the saddle rubbed your skin? | Yes | No |
| 15. Are you currently seen by a Physiotherapist, Occupational or Speech Therapist?
If yes, can you please give their name? | Yes | No |
| 16. Are you on medication that may need administered on site?
If yes, please note that MRT personnel are unable to administer medication. | Yes | No |



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www.muirfieldridingtherapy.org.uk
Registered charity: SC 028674

Epilepsy/Seizures - Additional Questions to be Completed if Answer to Q10 is YES

- a) What type of seizure do you experience?
- b) When did your last seizure occur?
- c) Is there a pattern to the seizures?
- d) Do you have triggers?
- e) Are there warning signs to look for?
- f) Can you describe your seizures?
- g) After the seizure ends, what might we expect?
- h) Are you tired the following day?
- i) Are you likely to require medication on site?

Additional information, please reference the question number

Signature: _____

Date: _____

Participant/Parent/Guardian/Carer
Delete as appropriate

Thank you for sharing this information, which will ensure you are safe and well supported. It will help draw up an Action Plan, if required. If we need to know more, we may contact you for further information, or ask one of our therapists to make contact for further discussion.

This information will only be shared with MRT personnel who will be assisting you.

Please update us with any changes to the information provided.