



2025 Lesson Season

Dear Riders, Family and Friends of Lothlorien,

I hope you have had a wonderful holiday season and are looking forward to the year ahead! Please look over and read the entirety of this packet, as there are many important details for the upcoming lesson season.

Things to note this year:

- We will make every effort to choose your preferred lesson time, and beyond that will be selecting classes based on variables such as horse availability, level of independence and group dynamics.
- ANYONE who will be in the barn/around the horses (any staff/family assisting their rider, etc.) is REQUIRED to wear sturdy closed toe shoes with a closed heel such as sneakers or boots. Crocs, sandals, dress shoes/flats etc. are not acceptable.
- Family/staff is required to be within eye/earshot of the rider unless explicit permission is given by the instructor.
- We ask that family/staff bringing riders be prepared to sidewalk if needed (wearing closed toe shoes). This will help lessons continue to run when there are shortages of volunteers.
- We are excited to continue enhancing the programming we offer to our riders and appreciate your patience as instructors and volunteers familiarize themselves with the new processes. Riders will now have the opportunity to spend more time with their horses, learning new skills through grooming and groundwork as part of their lessons. This approach gives riders greater autonomy and helps foster a sense of responsibility for the horses they ride.

Please refer to the Participant Handbook for specific information pertaining to rider and lesson policies.

Text or call (716) 339-7976 regarding lessons to reach our instructors.

Follow us on Facebook at Lothlorien Therapeutic Riding Center to keep up to date and see pictures throughout the season!

Sincerely,

Shelby Dytschkowskyj



2025 Lesson Season: Reservation Form

Please send your completed packet to:

Lothlorien Therapeutic Riding Center
15 Reiter Rd
East Aurora, NY 14052

OR

Email to program.ltrc@gmail.com

QUESTIONS?

Office Phone (716) 655-1335

Barn Cell (716) 339-7976

Rider Name _____

Phone # (if applicable) _____ Text? YES NO

Email _____

Address _____

City/State _____ Zip _____

Contact Person _____

Relationship to rider _____

Phone # _____ Text? YES NO Email _____

Parent or Legal Guardian (circle one) _____

Phone # _____ Text? YES NO Email _____

Address _____

City/State _____ Zip _____

For High Hurdles correspondence (including lesson cancellation), who is best person to contact?

- RIDER via text call email
- CONTACT PERSON via text call email
- PARENT/GUARDIAN via text call email





2025 Lesson Season: Payment Information

Lesson Rates:

8-week session: \$520

6-week session: \$390

4-week session: \$260



PLEASE DO NOT SEND PAYMENT WITH REGISTRATION PACKET



- **Third Party Payments:** Please speak with your Fiscal Intermediary/Broker or Care Coordinator to ensure that there are funds in the rider's budget for the program. Payment is due upon the completion of each session prior to continuing with services.
- **Private payments** are due no later than the second week of classes to continue riding.

If the rider is paying through a third party, please provide the following information:

Agency _____
 Care Coordinator Name _____
 Phone # _____
 Email _____
 Fiscal Intermediary Name _____
 Phone # _____
 Email _____
 TABS ID# (if applicable) _____

Please indicate to whom the invoice should be sent:



Name: _____
 Address: _____
 City/State/Zip: _____
 Phone: _____
 Email: _____





2025 Lesson Season: Schedule Information

- Please consider the season and typical weather when making your selections. Note that we do not follow all holiday closures.
- Please be aware that in order to create appropriate class groups, riders may not be scheduled until 3-4 weeks prior to the start of the session.
- Lothlorien Therapeutic Riding Center is not obligated to make-up classes and will not reimburse for missed classes that are cancelled by the rider.
- Riders new to us will be scheduled for a brief orientation prior to their first class.

See our Participant Handbook for further details on our scheduling, cancellation, make-up and weather policies



Lothlorien Horse Show

This year, we will offer a horse show on September 6th as a fun opportunity for riders to show off the skills they have been working on to their friends and families who are not regularly attending with them. The show will be limited to Lothlorien TRC participants and is a great confidence booster and way to experience a horse show in a safe and low-key environment. There is no obligation to participate as the show is simply an added opportunity for those who choose. Details on the show will be sent out to those who indicate interest below closer to the date.

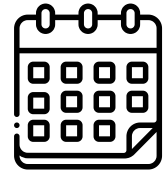


o Rider would like to participate in the Horse Show on September 6th, 2025





2025 Lesson Season: Session 1 Schedule Options



PLEASE MARK 3 or more choices for the day/time the rider would like to participate.
Indicate with a ★ next to the most preferred choice.



Rider is interested in:

- Primarily on-horse classes (horsemanship and riding)
- Off-horse only classes (horsemanship and ground based learning- no riding)

SESSION 1 March-April Class Options

Mon 3/3-4/21	<input type="checkbox"/> 10a <input type="checkbox"/> 11:30a	Fri 3/7-4/25	<input type="checkbox"/> 10a
Tues 3/4-4/22	<input type="checkbox"/> 10a <input type="checkbox"/> 5p <input type="checkbox"/> 6:30p	Sat 3/8-4/26	<input type="checkbox"/> 10a <input type="checkbox"/> 11:30a
Weds 3/5-4/23	<input type="checkbox"/> 10a <input type="checkbox"/> 11:30a <input type="checkbox"/> 5p <input type="checkbox"/> 6:30p		
Thurs 3/6-4/24	<input type="checkbox"/> 10 <input type="checkbox"/> 11:30 <input type="checkbox"/> 5p <input type="checkbox"/> 6:30p		





2025 Lesson Season: Rider Information/Background

Please complete this section as completely and accurately as possible to ensure the safety of the rider, horse and staff and to allow us to serve the rider as effectively as possible.

Rider Name: _____ Date of Birth: _____

Height: _____

Weight: _____ (required) *We have a strict 200lb on-horse weight limit.

Gender: _____

Diagnoses: _____

Medical/Surgical History: _____

Current Medications: _____

Adaptive Equipment: _____

Does the rider receive OT/PT services? o YES o NO

If YES, through which agency? _____

Behavioral Concerns: Lothlorien TRC staff and volunteers are not SCIP-R certified. We rely on participants' staff and family to manage behavioral situations that occur onsite. Should any behavioral changes occur during a session, we ask that you inform our staff; especially if it pertains to safety.

Please list any existing concerns:

Level of Supervision while in the Community: _____

Has this rider had horse/riding experience in any other capacity/program? Please describe:

Does the rider have specific areas of need? (social, behavioral, emotional etc.)

GOALS: What is the rider/family/caregiver hoping to achieve through therapeutic horseback riding? (increased strength, coordination, confidence, improved social interaction, recreation, etc.)

What is the rider's preferred learning style? (auditory, kinesthetic, visual, etc.)





2025 Lesson Season: Rider Information/Background

Please use the following scale when answering questions:

1 Always 2 Almost Always 3 Sometimes 4 Almost Never 5 Never



Social/Behavioral

Does the rider request help when they need it? 1 2 3 4 5

Does the rider have a difficult time with changes in their routine? 1 2 3 4 5

Does the rider get distracted easily by other people/objects in the room? 1 2 3 4 5

Does the rider work well with others in group settings? 1 2 3 4 5

Does the rider get frustrated easily? YES NO Please describe how they might react and the best way to help them in these situations? _____

Does the rider react to unexpected or loud noises? YES NO Please describe (will they stop talking, run away, cry, etc.): _____

Does the rider react to unexpected touch? YES NO Please describe (will they get angry, stop talking, run away, cry, etc.): _____

Is the rider anxious/fearful of heights? YES NO Please describe (will they avoid riding, yell, cry, etc.): _____

Cognitive/Physical

Does the rider get tired easily, especially when standing or holding a particular body position?
1 2 3 4 5

Does the rider require hand-over-hand assistance when completing tasks? 1 2 3 4 5

Does the rider bump into objects or need to be reminded to look where they are going?
1 2 3 4 5

Does it take the rider a long time to complete a task? 1 2 3 4 5

Is the rider able to identify shapes, colors, and read (at what level)? _____

Can the rider follow single step directions? YES NO Multi-step directions? YES NO

Please describe the rider's primary form of communication (verbal/nonverbal, communication device, sign language etc.) _____

Does the rider seek out activities that require a lot of movement or more sedentary activities?





2025 Lesson Season: Rider Ability Information

ABILITY Please mark an X in each box, or further comment	TOTAL ASSISTANCE	NEEDS SOME ASSISTANCE	INDEPENDENT/ SUPERVISION
Stair Climbing			
Mobility			
Transferring			
ADL Skills (grooming, dressing, etc.)			
BALANCING	POOR	FAIR	GOOD
While seated			
While standing			
While moving			
MOTOR SKILLS	POOR	FAIR	GOOD
Head Control			
Trunk Control			
Grip strength			
Muscle Strength			
Range of Motion in Arms			
Range of Motion in Legs			

Hearing: No ability Wears hearing aid No impairments

Vision: No ability Glasses No impairments

Any bone or joint limitations? YES NO _____

Any muscular limitations? (hypertonia/hypotonia, high spasticity, dystonia, rigidity etc.)

YES NO _____



2025 Lesson Season: Release Forms

Rider's Name: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____ Phone: _____

Health Insurance Company: _____ Phone: _____

List all pertinent medical information (allergies to food or drugs, special medical conditions):

Select One:

CONSENT PLAN

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 Suburban Adult Services, Inc. to:

- Secure and retain medical treatment and transportation if needed.
- Release rider records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the contacts listed above are unable to be reached.

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of Suburban Adult Services, Inc. In the event emergency treatment is required, I wish the following procedures to take place:

Consent Signature

Date

Non-consent Signature

Date

LIABILITY RELEASE

_____ (Rider's Name) would like to participate in the Lothlorien Therapeutic Riding Center program. I acknowledge the risks and potential for risks of horses and horseback riding. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors, or administrators, waive and release forever all claims for damages against Suburban Adult Services, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in the Lothlorien Therapeutic Riding Center Program.

Signature: _____ Date: _____

Parent / Guardian / Correspondent / or Rider (if over 21, no guardian)

PHOTO RELEASE (optional)

I hereby consent to and authorize the use and reproduction by Suburban Adult Services, Inc., of any and all photographs and any other audio / visual materials taken of me/my son/my daughter/ my ward for promotional printed material, social media, website, educational activities or for any other use for the benefit of the program.

Signature: _____ Date: _____

Parent / Guardian / Correspondent / or Rider (if over 21, no guardian)



2025 Lesson Season: Physician Release Form

Dear Dr. _____,

Your patient _____ has shown an interest in participating in our therapeutic horsemanship/riding program. In order to safely provide this service, our center requests that you complete/update this Medical History and Physician's Statement Form. Please provide us with your recommendations regarding the activity/exercise prescription for this individual and any restrictions and/or limitations that would limit their participation in this program. Please note that the following conditions may suggest precautions and contraindications to equine activities - please indicate whether these conditions are present and to what degree. Thank you for your time and cooperation in completing this form.

Orthopedic

Atlantoaxial Instability- include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation
Tethered Cord/Hydromyelia

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire setting
Hemophilia
Medical Instability
Migraines
PVD
REspiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders

Other

Weight Control Disorder
Age- under 4 years
Indwelling Catheters/Medical Equipment
Medications - e.g. photosensitivity
Poor Endurance
Skin Breakdown

Diagnoses: _____

Past / Prospective Surgeries: _____

Seizures / type? _____ Controlled? YES NO Date of last seizure: _____

Down syndrome? YES NO

If YES, date of cervical spine x-ray: _____ Result: _____ (must be negative to ride)

Shunt present? YES NO

Please check any limitations to any muscle strength activation movements or limited mobility:

Chest: ____ Shoulders: ____ Back: ____ Hips: ____ Biceps: ____ Legs: ____

Limitations to any cardiovascular/endurance training exercises, primarily during periods of walking/jogging? YES NO

Other limitations/restrictions to on-horse/riding activities? YES NO Please specify any that are appropriate:

Physician's Recommendation

I am not aware of any contraindications in participating in this horsemanship program

I believe this individual can participate on horse, but urge caution because:

 This individual should NOT participate in ON-HORSE/Riding activities, but MAY participate in OFF-HORSE activities:

 I recommend this individual NOT participate in the program.

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted services/activities. I understand that Lothlorien Therapeutic Riding Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Lothlorien Therapeutic Riding Center for ongoing evaluation to determine eligibility for participation.

Signature: _____ Date: _____