Mounted Angels

Free horseback riding lessons for children with disabilities. Lessons are held on Thursday evenings during June and July at the Pike County Fairgrounds in Pleasant Hill, Illinois.

Riders must have forms completed by their doctor and parents in order to ride. Contact Mounted Angels for forms.

Volunteers are always needed! Anyone 15 and older may volunteer. Experience with horses is not required, we provide training to meet our safety requirements.

Mounted Angels
Martha Sheppard
10362 46th St.
Pearl, IL 62361
The smiles are contagious!
Each year, 9 to 16 disabled children have participated.

Mounted Angels was started in 1989.
Mounted Angels was started when Judy Schlieper worked at the Pike County Health Department and was required to do a project to complete her degree in nursing. Judy had an interest in horses, having raised them with her husband Ed. She was also interested in the emerging field of equine therapy, where horses were used to help disabled children master new skills. So, for her project, she chose to start a therapeutic riding program. Judy held meetings and started the process of bringing together horse people from the community, along with health professionals and parents of disabled children. Early board members for Mounted Angels included: Judy and Dennis Douglas, Dan and Marcia Allen, Mike and Lynn Hollahan.

Mounted Angels Therapeutic Horsemanship is a non-profit organization that formed to provide free riding lessons to disabled children. Each June, the Mounted Angels hold a training program to orient and train 40 volunteers and horses. Mounted Angels has no paid employees and relies solely on donations and volunteers for all activities. All horses for the program are provided by volunteers at their own expense. The Pike County Fair Board provides their facilities at Pleasant Hill at no charge.

Professionally recognized
- Mounted Angels is a member center with PATH International. Debbie Laux is a registered instructor with PATH. Judy and Dennis Douglas are both trained instructors with Spirit Horse. The instructors attend training throughout the year to stay current in the field of Therapeutic Riding. Martha Sheppard serves as the coordinator and assists with lessons. The current board includes: Judy and Dennis Douglas, Sara and Bobby Gresham, and Lanny and Darla Lemons.

Contact Us
Mounted Angels
Martha Sheppard
10362 465th St.
Pearl, IL 62361
Home-217-829-4409
Cell-217-257-5702
marthashep@hotmail.com
Authorization for Emergency Medical Treatment Form

Participant

Name: ____________________________ DOB: __________

Phone Numbers: ___________________ __________________________

Address: __________________________ __________________________

Physician’s Name: ___________________ Preferred Medical Facility: ______________________

Health Insurance Company: ___________ Policy Number: ______________________

Allergies to medications: __________________________

Current Medications: __________________________

In the event of an emergency contact:

Name: ___________________ Relation: __________ Phone: __________________________

Name: ___________________ Relation: __________ Phone: __________________________

Name: ___________________ Relation: __________ Phone: __________________________

Sign only one plan below.

Consent Plan

In the event emergency medical treatment/aid is required due to illness or injury while at a Mounted Angels session, I authorize Mounted Angels to:

1. Secure and retain medical treatment and transportation if needed.
2. Release participant/volunteer 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 deemed "life saving" by the physician. This provision will only be invoked if the emergency contact named above cannot be reached.

Consent Signature: ___________________________ Date: __________

Signed in presence of center staff

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during a Mounted Angels session and

__ Parent or guardian will remain on site at all times during a Mounted Angels session.
__ In the event emergency treatment/aid is required, I wish the following to take place:

________________________

Non-Consent

Signature: ___________________________ Date: __________

Signed in presence of center staff
RELEASE, WAIVER, HOLD HARMLESS, AND INDEMNIFICATION AGREEMENT

The undersigned, as a Participant/Spectator/Visitor/Guest/Client (collectively "Participant"), on his/her own behalf and, if applicable, as the Parent(s)/Legal Guardian(s) of a minor Participant (minor included as "Participant"), for good and valuable consideration, agrees to the following terms and conditions of this Release, Waiver, Hold Harmless, and Indemnification Agreement ("Agreement"):  

1. Assumption of Risk and Waiver: Participant understands and accepts the risks of engaging in Equine Activities, while mounted or unmounted, as well as merely being near a horse, mule, or pony (collectively "equine"), including: (i) The propensity of an equine to behave in ways that may result in injury, harm, or death to persons on or around them; (for example: jump, run, kick, buck, bolt, spin, rear up, strike, bite, etc.); (ii) The unpredictability of an equine’s reaction to sounds (for example: machinery, equipment, doors opening and closing, snow and ice falling, rain, wind, thunder, voices, etc.), sudden movement, and unfamiliar objects, persons, other animals, or other things; (iii) Certain hazards such as surface and subsurface conditions; (iv) Collisions with other equines or objects; and (v) The potential of a participant to act in a negligent manner that may contribute to injury to Participant or others, such as failing to maintain control over the animal, or not acting within his or her ability. Participant agrees that engaging in equine activities under this Agreement includes, but is in no way limited to, those defined in the Illinois Equine Activity Liability Act, as well as riding another’s equine, petting, leading, driving, feeding, watching, transporting, and otherwise interacting with or merely being in the vicinity of equines ("Equine Activities"). Participant understands the injuries, death, loss (both personal and property), and property damage that may result from the accepted risks of engaging in Equine Activities or just being near an equine, that equines are powerful and have the potential to be dangerous, even without warning, and that the risks listed in this Agreement are just a sampling and Participant is not relying on Released Parties (as defined below) to list all possible equine-related risks. Participant therefore agrees, on his/her own behalf and on behalf of his/her minor Participant, that he/she understands and agrees to assume the risks and dangers inherent in Equine Activities, agrees to at all times to be responsible for Participant’s personal safety, remain financially responsible for Participant’s medical expenses, and waives Participant’s right to any claims arising from participation in or observation of any Equine Activities, riding a horse belonging to Participant or someone else, whether on or off the property where the horse is stabled and/or transported to, being near an equine, or merely being present on real property owned, leased, rented, borrowed, visited, organized upon, trail riding across, or otherwise occupied by Mounted Angels Therapeutic Horsemanship, and its respective officers, directors, guarantors, indemnitors, agents, employees, volunteers, independent contractors, guests, visitors, invitees, trainers, organizers, guides, side walkers, therapists, and others acting on their behalf (collectively “Released Parties”) regardless of whether or not Participant’s presence on such real property is related to equines or Equine Activities.  

2. Release, Hold Harmless, Indemnification: Participant agrees to release and hold Released Parties harmless for any illness, injury, death, damage, or other loss (collectively “Loss”) incurred, by Participant, or to Participant’s property, unless caused by Released Parties’ willful and wanton misconduct. Participant agrees to indemnify Released Parties against any Loss sustained or suffered by any third party, whether caused by Participant directly or indirectly, and which includes reimbursement of Released Parties’ attorneys’ fees.  

3. Governing Law and Time Limitation: This Agreement shall be construed and enforced in accordance with the laws of the State of Illinois. All disputes relating to the interpretation and enforcement of this Agreement shall be resolved exclusively by the state court in Pike County, Illinois. The parties hereto hereby submit to the jurisdiction and venue of the Court for such purpose. Participant agrees that any and all claims and/or causes of action for Loss by Participant against the Released Parties must be brought within one (1) year of the date accrued and any claim for personal property Loss is limited to $500.00 (Five Hundred Dollars).  

4. Attorneys’ Fees: Participant agrees to reimburse Released Parties for any and all attorneys’ fees and costs incurred by Released Parties in enforcing the terms of this Agreement and/or in defending or prosecuting any claims or causes of action involving, or in any way relating to, Participant.  

5. Participant Certification: Participant certifies that he/she has read this entire Agreement and understands, agrees, and intends on his/her own behalf, and on behalf of minor Participant, spouse, heirs, agents, representatives, relatives, successors, and assigns, to be bound by all of the terms and conditions contained herein.  

WARNING UNDER THE EQUINE ACTIVITY LIABILITY ACT, EACH PARTICIPANT WHO ENGAGES IN AN EQUINE ACTIVITY EXPRESSLY ASSUMES THE RISKS OF ENGAGING IN AND LEGAL RESPONSIBILITY FOR INJURY, LOSS, OR DAMAGE TO PERSON OR PROPERTY RESULTING FROM THE RISK OF EQUINE ACTIVITIES.

---

Date: _______________________________ Signature: __________________________________________
Participant signing on own behalf and as Parent/Legal Guardian of Minor Participant

Signer’s Printed Name: _______________________________ Address: _______________________________
Date: _______________________________ Signature: __________________________________________
Add’l! Parent/Legal Guardian of Minor Participant

Signers’ Printed Name: _______________________________ Address: _______________________________
Phone: _______________________________ Phone: _______________________________
Minor Participant’s Name and Date of Birth: _______________________________
To be completed by Physician or Health Care Provider

Date: __________________________
Dear Health Care Provider,
Your patient, _____________________________________________ (fill in rider’s name)
is interested in participating in supervised equine activities. In order to safely provide this service, our
center requests that you complete the attached Medical History and Physician’s Statement Form.
Please note that the following conditions may suggest precautions and contraindications to equine
activities. Therefore when completing this form, please note whether these conditions are present and
to what degree.

Orthopedic
Atlantoaxial Instability-including neurologic
symptoms
Coxa Arthritis
Cranial Deficits
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 11 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 (RA, MS...)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Other
Age-under 4 years
Indwelling Catheters/Medical Equipment
Medications-i.e. photosensitivity
Poor Endurance
Skin Breakdown

Thank you very much for your assistance. If you have any questions or concerns regarding this patient’s
participation in equine assisted activities, please feel free to contact the center at the address/phone
indicated above.
Sincerely,

Martha Sheppard

Mounted Angels Physician Form 1.2 for New Riders

Please complete back of page.
Participant’s Medical History and Physician’s Statement continued.

Participant: ___________________________ DOB: ________ Height: ________ Weight: ________
Address: __________________________________________ Date of Onset: ________________
Diagnosis: ________________________________________ Special Precautions/Needs: ______
Past/Prospective Surgeries: __________________________
Medications: ______________________________________
Seizure Type: ___________________________ Controlled: Y N Date of Last Seizure ______
Shunt Present: Y N Date of last revision: ____________

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N Braces/Assistive Devices: ______
For those with Down Syndrome: AtlantoDens Interval X-rays, date: _______________Result: + -
Neurologic Symptoms of AtlantoAxial Instability: __________________________

Please indicate current or past special needs in the following systems/area, including surgeries:

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<tr>
<th>System</th>
<th>Y</th>
<th>N</th>
<th>Comments</th>
</tr>
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<td>Auditory</td>
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<td>Visual</td>
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<td>Learning Disability</td>
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<td>Cognitive</td>
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<td>Emotional/Psychological</td>
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<td>Pain</td>
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<tr>
<td>Other</td>
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Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the NARHA center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the NARHA center for ongoing evaluation to determine eligibility for participation.

Name/Title: ___________________________________________ MD DO NP PA Other ______
Signature: ___________________________________________ Date: ______________________
Address: ____________________________________________
Phone: _____________________________________________ License/UPIN Number: __________
Participant’s Application and Health History
To be completed by participant or parent/legal guardian

**General Information**
Participant: ____________________________
DOB: ___________ Age: _______ Height: ________ Weight: _________ Gender:  M  F
Address: ____________________________________________
Phone: ___________________________ Email: ________________
Employer/School: _______________________________________
Parent/Legal Guardian: __________________________________
How did you hear about the program: ____________________________

**Health History**
Diagnosis: ___________________________ Date of Onset: ____________
Please indicate current or past special needs in the following areas:

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<th>Y</th>
<th>N</th>
<th>Comments</th>
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<td>Emotional/Mental</td>
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<td>Health</td>
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<td>Behavioral</td>
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<td>Bone/Joint</td>
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<td>Muscular</td>
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<td>Thinking/Cognition</td>
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<tr>
<td>Allergies</td>
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</tbody>
</table>

Doctor: __________________________________________ Office Phone: ____________________________
Address: __________________________________________

**Medications** (include prescription, over the counter, name, dose, and frequency):
____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________

Mounted Angels Form 1.4  Please complete back of page.
Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

**Physical Function** (Mobility skills such as transfers, walking, wheelchair use, driving, etc.)

________________________
________________________
________________________
________________________

**Psycho/Social Function** (Work, school, grade completed, leisure interests, relationships, family structure, support systems, companion animals, fears/concerns, etc.)

________________________
________________________
________________________
________________________

**Goals** (Why are you applying for riding? What would you like to accomplish?)

________________________
________________________
________________________
________________________

No participant will be accepted for riding instruction until this form has been completed by the parent/legal guardian. Riding instruction will be under strict supervision and although every effort will be made to avoid any accident, NO LIABILITY can be accepted by any of the individuals or organizations concerned with this instruction. I have discussed this activity with the participant’s Doctor and his/her authorization has been given.

Signature: ___________________________ Date: ___________________________

**Photo Release**

I ___ DO

___ Do Not

Consent to and authorize the use and reproduction by Mounted Angels of 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.

Signature: ___________________________ Date: ___________________________

Client, parent or legal guardian, signed in the presence of center staff

________________________

To Be completed by Mounted Angels Personnel:

Approved for Instruction by: ___________________________ Date: ___________________________
Volunteer/Staff Information Form and Health History

General Information
Name: __________________________________________ Date: ________________
Address: __________________________________________ Date of Birth: __________
Address: __________________________________________
Phone numbers: ____________________________________
Email: ____________________________________________
Employer/School: __________________________________
Parent/Legal Guardian: ________________________________
How did you hear about the program: ____________________

Health History
Recent medical tests: _____ Last Tetanus Shot: ___________ Tuberculosis Test + __ Date________
(Consult your physician or local health department if you are not up to date with these shots/tests)

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries, or lifestyle changes.

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
Allergies: ____________________________________________________________
________________________________________________________________________________________
Medications: __________________________________________________________
________________________________________________________________________________________

Check which areas you are interested in:
Program
__ Horse Handling
__ Sidewalking w/ a student
__ Stable Management
__ Facility Repairs

Special Events
__ Horse Show
__ Fundraising
__ Special Olympics
__ Trail Rides

Administration
__ Public Relations
__ Grant Writing
__ Newsletter
__ Volunteer Recruitment
__ Photography/Video
__ Budget & Finance
__ Future Planning

I understand that the information provided above is accurate to the best of my knowledge. I know of no reason why I should not participate in this center’s program.

Signature: __________________________________________ Date: __________________
(signed in presence of center staff)

Mounted Angels Form 2.1
Please complete back of page.
Volunteer/Staff Information Form and Health History Continued

Photo Release

I __DO __Do Not

Consent to and authorize the use and reproduction by Mounted Angels of 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.

Signature: ___________________________ Date: ___________________________

Background Information

Have you ever been charged with or convicted of a crime? __Yes __No

Please explain: __________________________________________________________

Current Driver’s License Y N License Number __________________________ State __________________

I, __________________________ (volunteer/staff) authorize Mounted Angels to receive information from any law enforcement agency, including police departments and sheriff’s departments, of this state or any other state or federal government, to the extent permitted by state and federal law, pertaining to any convictions I may have had for violations of state or federal criminal laws, including but not limited to convictions for crimes committed upon children or animals.

I understand that such access is for the purpose of considering my application as an employee/volunteer, and that I expressly DO NOT authorize the NARHA center, its directors, officers, employees, or other volunteers to disseminate this information in any way to any other individual, group, agency, organization or corporation.

Signature: __________________________ Date: __________________________

Confidentiality Agreement

I understand that all information (written and verbal) about participants at this NARHA center is confidential and will not be shared with anyone without the expressed written consent of the participant and their parent/guardian in the case of a minor.

Signature: __________________________ Date: __________________________

Release of Liability

The undersigned, for and in consideration of volunteering with Mounted Angels Therapeutic Horsemanship Program does/do hereby forever release, acquit, discharge and hold harmless the Mounted Angels Therapeutic Horsemanship Program, its officers, trustees, agents, employees, representatives, volunteers, successors and assigns, for all manner of claims, demands and damages of every kind and nature whatsoever, which the undersigned or said minor may now, or in the future, have against the Mounted Angels Therapeutic Horsemanship Program, its officers, trustees, agents, employees, representatives, volunteers, successors or assigns on account of any personal injuries, physical or mental condition, known or unknown, to the person of said minor and the treatment therefore as a result of, or in any way growing out of, the acts of the Mounted Angels Therapeutic Horsemanship Program, its officers, trustees, agents, employees, representatives, volunteers, successors or assigns, including, but not limited to their negligence or gross negligence, in rendering the services above described or in any way incidental thereto.

Signature: __________________________ Date: __________________________

Mounted Angels Form 2.1
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WARNING UNDER THE EQUINE ACTIVITY LIABILITY ACT, EACH PARTICIPANT WHO ENGAGES IN AN EQUINE ACTIVITY EXPRESSLY ASSUMES THE RISKS OF ENGAGING IN AND LEGAL RESPONSIBILITY FOR INJURY, LOSS, OR DAMAGE TO PERSON OR PROPERTY RESULTING FROM THE RISK OF EQUINE ACTIVITIES

Date: __________________________ Date: __________________________
Signature: __________________________ Signature: __________________________
Participant signing on own behalf and as Parent/Legal Guardian of Minor Participant Add’l Parent/Legal Guardian of Minor Participant
Signer’s Printed Name: __________________________ Signers’ Printed Name: __________________________
Address: __________________________ Address: __________________________
Phone: __________________________ Phone: __________________________
Minor Participant’s Name and Date of Birth: __________________________
Authorization for Emergency Medical Treatment Form

Participant __ Staff __ Volunteer ___

Name: ___________________________ DOB: __________________

Phone Numbers: _____________________________________________

Address: ___________________________________________________

Physician’s Name: ___________________________ Preferred Medical Facility: ___________________________

Health Insurance Company ___________________________ Policy Number ___________________________

Allergies to medications: _________________________________________

Current Medications: ___________________________________________

In the event of an emergency contact:

Name ___________________ Relation ______ Phone __________________

Name ___________________ Relation ______ Phone __________________

Name ___________________ Relation ______ Phone __________________

Sign only one plan below.

Consent Plan

In the event emergency medical treatment/aid is required due to illness or injury while at a Mounted Angels session, I authorize Mounted Angels to:

1. Secure and retain medical treatment and transportation if needed.
2. Release participant/volunteer 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 deemed “life saving” by the physician. This provision will only be invoked if the emergency contact named above cannot be reached.

Consent Signature: ____________________________ Date: ____________
Signed in presence of center staff

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during a Mounted Angels session and

__ Parent or guardian will remain on site at all times during a Mounted Angels session.
__ In the event emergency treatment/aid is required, I wish the following to take place:

__________________________________________

Non-Consent
Signature: ____________________________ Date: ____________
Signed in presence of center staff