



## **INFORMATION ON THE RDA CONSENT FORM**

**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;**

<b>INFORMATION SHEET</b>	- about the consent form
<b>SECTION A - CONSENT FORM</b>	- for Parent, Guardian or Rider over 18
<b>SECTION B - MEDICAL FORM</b>	- for your usual Medical Practitioner
<b>SECTION C –</b>	- applicable to riders with Down Syndrome
<b>SECTION D -</b>	- applicable to riders with Spinal Fusion
<b>REVIEW Form</b>	- for conditions which are not stable

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 participants application is processed, the information contained in the Form is stored securely, and is accessible only to the RDA Coaches 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 consent must be reviewed at least every three years or more often as the condition requires.

**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 RDAA Affiliated Centre in order for your application to be processed.
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.

**The Coaching Coordinator RDA CENTRE**

*(Address to be included by the centre)*

.....

.....P Code.....

**Phone**.....

**PARTICIPANT INFORMATION**

Name of Participant .....Date of Birth.....

Address .....

..... P'Code .....Telephone No .....

Height .....Weight .....Male/Female.....

Nature of Disability .....

Age of onset of disability .....

Any other relevant information.....

.....

Member of the Ambulance Service Yes / No M'ship No. ....

I give permission for ..... (*Insert participant's full name*) to be involved in Riding for Disabled Association of Australia Limited activities.

(Please circle) YES/NO

In some circumstances, RDA Coaches need further information about a rider's medical condition, in addition to the information given on the Medical Form.

I ..... (*insert participant or participants legal guardians full name*) 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.

(Please circle) YES/NO

I agree that any photograph taken of the above named participant during an RDA activity, may be used to further the objects of RDA generally or this centre in particular.

(Please circle)YES/NO

I consent for the above named participant to be allowed emergency medical attention, if necessary, during the participation in any activity.

(Please circle) YES/NO

I understand that no liability can be accepted by the Association or Centre concerned in the event of an injury or accident occurring.

Signature.....

I understand that RDA reserves the right to refuse any person access to the RDA program if it is reasonably believed that participation may be detrimental to the person, the coaches and helpers and / or horses.

Signature.....

**SECTION A - CONSENT FORM:**

*(continued from page 3)*

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

Signature ..... Date .....

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

EMERGENCY CONTACT DETAILS: .....

ADDRESS: .....

TELEPHONE: Home .....Work .....  
Mobile.....

Relationship to participant .....

**SECTION B - MEDICAL FORM**

(CONFIDENTIAL)

Section B, (and C and D if required) are only to be completed by an appropriately qualified registered Medical Practitioner

Please use block letters

Name of participant ..... Date of birth .....

Name of Medical Practitioner .....

Address .....

Telephone No .....

Diagnosis .....

Brief History (if applicable) .....

Does the participant have: (please ensure ALL questions are completed)

1.	Medication	Yes	No	17.	Heart Problems	Yes	No
2.	Epileptic fits	Yes	No	18.	Drainage Devices	Yes	No
3.	Fainting Turns	Yes	No	19.	Paralysis	Yes	No
4.	Postural Hypotension	Yes	No	20.	Flaccidity	Yes	No
5.	Hypertension	Yes	No	21.	Allergies	Yes	No
6.	Impaired Hearing	Yes	No	22.	Muscle overactivity	Yes	No
7.	Impaired Sight	Yes	No	23.	Inflammation or pain		
8.	Impaired Speech	Yes	No		in the joints	Yes	No
9.	Impaired Sensation	Yes	No	24.	Impaired Bladder /		
10.	Impaired Balance	Yes	No		Bowel control	Yes	No
11.	Impaired Circulation	Yes	No	25.	Use of any Splints/ Braces		
12.	Asthma		Yes	No	Corsets/Prostheses	Yes	No
13.	Cranial Shunt	Yes	No	26.	Is the participant a carrier		
14.	Diabetes	Yes	No		of any infectious disease	Yes	No
15.	Skin Problems	Yes	No	27.	Scoliosis	Yes	No
16.	Chronic Airways	Yes	No				

28.	Intellectual Disability	Yes	No	Specific Learning Difficulty	Yes	No
	Developmental Delay	Yes	No	Level of support required	HIGH	MED
					LOW	

29. Down Syndrome Yes No **if YES, SECTION C, must be completed as further medical information is required BEFORE we can consider this applicant.**

30. Spinal Fusion Yes No **if YES, SECTION D, must be completed as further medical information is required BEFORE we can consider this applicant.**

Please provide FULL details of any YES answers:

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

If relevant, please outline any other medical condition or information which may affect the participants 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.

.....  
.....  
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, Signature and Telephone Number of the Medical Practitioner**

Name: .....

Signature: .....

Provider Number: .....

*(Block letters please)*

Telephone: .....

Date .....

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

Section **C** and Section **D** to be returned if applicable

**THANK YOU**

**SECTION C**

<b>ADDITIONAL INFORMATION FOR APPLICANTS with DOWN SYNDROME</b>	<b>(CONFIDENTIAL)</b>
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RDA Limited 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, and 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 review of the client is necessary?

**YES / NO**

**Name, Signature and Telephone Number of the Medical Practitioner**

Name: .....

Signature: .....

Provider Number: .....

*(BLOCK LETTERS PLEASE)*

Telephone: .....

Date .....

*Attach the completed form to Section B and return to the nominated RDA centre on Page 2.*

**SECTION D**

<b>ADDITIONAL INFORMATION FOR APPLICANTS with SPINAL FUSION</b>	<b>(CONFIDENTIAL)</b>
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RDA Policy requires that riders with a Spinal Fusion ( eg Harrington or CD Rods) must be examined by an Orthopaedic Specialist **prior** to the commencement of a riding program.

To be completed by an Orthopaedic Specialist

**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, Signature and Telephone Number of the Orthopaedic Specialist**

Name: .....

Signature: .....

Provider Number: .....

*(Block letters please)*

Telephone: .....

Date .....

*Attach the completed form to Section B and return to the nominated RDA centre on Page 2.*

**MEDICAL CONSENT REVIEW FORM**

(CONFIDENTIAL)

*(To be completed by the medical practitioner where there is a change in the medical status of the client)*

*This MEDICAL CONSENT REVIEW FORM is required to be attached to the clients original MEDICAL CONSENT FORM'*

RDA Limited Coaches may need further information about a rider / driver's medical condition, in addition to the information given on this form. 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.

This form is to be used where a participant has a condition which may deteriorate or improve over time. It should be used as frequently as required by the condition, but at least every three years.

RDA Limited 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.

Name of Participant .....

Address: .....

Phone No: ..... Fax No: .....

Mobile No: .....

Height .....Weight .....

Nature of Disability .....

Age of onset of disability.....

Any other relevant information .....

Date of completion of the initial Medical Consent Form;.....*(insert date, attach copy of original)*.The Medical practitioner should read the original Medical Consent Form and then indicate and detail on this form any significant change 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 RDA Limited 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, Signature and Telephone Number of the Medical Practitioner

Name: .....

Signature: .....

Provider Number: .....

*(Block letters please)*

Telephone: .....

Date .....