



Valkyrie's Kindred Keep

Therapeutic Riding Program • Rider Intake Packet

Welcome

Dear Future Valkyrie Family,

Welcome. We are so grateful that you have found your way here.

At Valkyrie's Kindred Keep, we believe in the quiet, powerful connection between horse and human. Our therapeutic riding and equine-assisted programs are designed to support growth in physical ability, confidence, emotional resilience, communication, and a deeper sense of self. Here, the horses are our partners. Through their honest feedback and gentle presence, we create space for each participant to be seen, supported, and encouraged in their own unique journey.

We welcome individuals of all abilities and backgrounds. Whether your goals are physical, emotional, developmental, or simply to experience connection and joy, we are honored to walk alongside you.

What to Expect

Therapeutic riding sessions, ground-based equine interactions, activities that support balance, coordination, and strength, and opportunities to build confidence, communication, and emotional awareness.

Getting Started

Please complete this Rider Intake Packet in full. Once your paperwork has been received and reviewed, we will reach out to discuss next steps and scheduling.

Our Commitment to You

We are committed to creating a space that is safe and supportive, inclusive and respectful, grounded in compassion and presence, and centered around the well-being of both participants and horses.

This is more than a program — it is a community.

We are truly honored to welcome you into the Kindred Keep. We look forward to meeting you, learning your story, and witnessing the connection that unfolds.

With gratitude,

Marina Premoli

Founder, Valkyrie's Kindred Keep



1. Participant Information

Participant Name		Date of Birth	
Gender	M / F	Weight	
Height		Participant is a	Minor / Adult with legal guardian / Independent adult
Street Address		City / State / Zip	
Current Diagnosis		Current Treatment / Services	

Parent / Guardian / Primary Contact: _____

Phone: _____ **Email:** _____

Parent / Guardian / Secondary Contact: _____

Phone: _____ **Email:** _____

School or educational facility presently attending:

Emergency Contact (other than parent / guardian listed above)

Name: _____ **Phone:** _____

Regional Center Information (if applicable)

Is the participant a Regional Center client? Yes / No _____

Coordinator Name: _____ **Phone:** _____



2. Medical, Developmental & Functional Information

Primary Diagnosis: _____

Secondary Diagnosis: _____

Please note: Before riding, participants with a diagnosis of Down syndrome may be required to provide a physician's note verifying they are cleared for participation and do not show symptoms consistent with atlantoaxial instability.

Item	Yes	No	Comments
Walk independently?	☐	☐	
Poor sitting / standing balance?	☐	☐	
Use wheelchair, walker, braces, or orthotics?	☐	☐	
Use any other medical equipment or devices?	☐	☐	
Speech / language difficulties?	☐	☐	
Fine motor skill difficulties?	☐	☐	
Gross motor skill difficulties?	☐	☐	
Asthma or breathing problems?	☐	☐	
Allergies (hay, horses, food, etc.)?	☐	☐	
Pain?	☐	☐	
Emotional / behavioral challenges?	☐	☐	
Heart / circulation issues?	☐	☐	
Short- or long-term memory loss?	☐	☐	
Current or past seizure history?	☐	☐	
Hearing difficulties?	☐	☐	
Sensory issues?	☐	☐	
Fear of heights?	☐	☐	
Fear of animals / horses?	☐	☐	

Please feel free to write on the back of this form or attach additional pages, reports, or notes that would be helpful for lesson planning and safety.



3. Participation History, Goals & Additional Information

Has the participant had any previous experience with therapeutic riding or horses? Yes / No

If yes, please explain:

Goals: What are you hoping to accomplish through participation?

Comments: Please share anything else that would be helpful in lesson planning.

Please check any concerns or areas currently affecting the participant:

- | | | |
|--|--|---|
| ☐ Depressed mood | ☐ Anxious mood | ☐ Excessive worrying |
| ☐ Impulsivity | ☐ Fatigue | ☐ Loss of interest |
| ☐ Sleep difficulties | ☐ Grief / loss | ☐ Comfort eating |
| ☐ Poor concentration / focus | ☐ Relationship stress | ☐ Drug / alcohol abuse |
| ☐ Difficulty with self-expression | ☐ Irritable mood | ☐ Racing thoughts |
| ☐ Loss of appetite | ☐ Excess energy | ☐ Low self-esteem |



4. Seizure Information (complete only if applicable)

Does the participant have seizures? Yes / No

What may cause the seizures?

On average, how often do they occur?

Are there any warning signs before a seizure starts?

What is the average duration of a seizure?

How does the participant feel and behave after a seizure? How long does this last?

How would you like us to handle the situation if a seizure occurs during programming?

Is there anything else we should know about the seizures?



5. Physician Medical Release / Health Information

This form should be completed by the participant's physician or other qualified medical provider.

Patient Name		Parent / Guardian Name and Contact	
Patient Date of Birth		Height / Weight	
Diagnosis		Date of Onset	
Primary Disability		Other Concerns	
Hospitalizations		Shunts / Assistive Devices	
Seizures / Allergies		Present Medications	

Physical Evaluation

Skin / Circulation		Neuro / Sensation	
Heart / Lungs		Balance / Coordination	
Bowel / Bladder		Allergies	
Vision		Hearing	
Speech		Spasticity / Rigidity	

For participants with Down syndrome — Neurological exam for Atlantoaxial Instability: Present / Not Present

Other precautions / contraindications to therapeutic horseback riding:

In my professional opinion, this patient can receive therapeutic horseback riding instruction under appropriate supervision at Valkyrie's Kindred Keep.

Provider Signature

Printed Name

Date

Provider Address / Phone: _____



6. Emergency Medical Authorization

In the event emergency treatment or medical aid is required due to illness or injury during services, or while on the property, I authorize Valkyrie's Kindred Keep to:

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

Client Name: _____

Client Phone: _____

Client Address: _____

Allergies: _____

Emergency Contact #1: _____

Phone Number: _____

Emergency Contact #2: _____

Phone Number: _____

Physician Name: _____

Preferred Medical Facility: _____

Health Insurance Company: _____

Policy Number: _____

Consent Plan

This authorization includes x-rays, surgery, hospitalization, medication, and any treatment procedure deemed lifesaving by a physician. This provision will only be invoked if the responsible party cannot be reached.

Consent Signature (Client / Parent /
Guardian)

Print Name

Date



7. PT / OT Collaboration Form

Please give this form to the PT / OT the rider is working with on a regular basis. This information is helpful for our instructors and will remain confidential within the program.

Client Name:

Name of PT / OT:

PT / OT Contact Information:

Short-Term Goals:

Long-Term Goals:

Other Objectives:

Degree of Coordination:

Areas of Strength:

Any Precautions:



8. Speech Therapy Collaboration Form

Please give this form to the Speech Therapist the rider is working with on a regular basis. This information is helpful for our instructors and will remain confidential within the program.

Client Name:

Name of Speech Therapist:

Speech Therapist Contact Information:

Short-Term Goals:

Long-Term Goals:

Other Objectives:

Degree of Coordination:

Areas of Strength:

Any Precautions:



9. Educator / Mental Health Provider Form

Please give this form to the Educator and / or Mental Health Provider the rider is working with on a regular basis. This information is helpful for our instructors and will remain confidential within the program.

Client Name:

Name of Educator and / or Mental Health Provider:

Educator and / or Mental Health Provider Contact Information:

Short-Term Goals:

Long-Term Goals:

Other Objectives:

Degree of Coordination:

Areas of Strength:

Any Precautions:



10. Availability & Scheduling Preferences

Session Information

- Availability: By appointment, with weekday and weekend options
- Location: Valkyrie Equine Experiences, Paso Robles
- Instructor: Marina Premoli, CTRI, ESMHL, EALF, HeartMath Coach

Please check any times that generally work best for your family. Final scheduling is based on current program availability.

Day	Slot 1	Slot 2	Slot 3	Slot 4	Slot 5	Slot 6	Slot 7
Monday	☐ 9:00	☐ 10:15	☐ 11:30	☐ 1:00	☐ 2:15	☐ 3:30	☐ 4:45
Tuesday				☐ 1:00	☐ 2:15	☐ 3:30	☐ 4:45
Wednesday	☐ 9:00	☐ 10:15	☐ 11:30	☐ 1:00	☐ 2:15	☐ 3:30	☐ 4:45
Thursday	☐ 9:00	☐ 10:15	☐ 11:30				
Friday	☐ 9:00	☐ 10:15	☐ 11:30	☐ 1:00	☐ 2:15	☐ 3:30	☐ 4:45
Saturday	☐ 9:00	☐ 10:15	☐ 11:30				
Sunday	Special events only						

Comments / preferred days or times:



11. Liability Release

1. Valkyrie's Kindred Keep Therapeutic Riding Program is carefully organized and supervised. Staff, volunteers, and horses are thoughtfully selected, and safety equipment is used for all riders. However, horseback riding and interaction with horses involve inherent risks, including the risk of serious injury or death. I acknowledge, understand, and voluntarily assume and accept all such risks associated with participation.
2. No participant may be accepted into the program without a signed liability release. All participants, parents, and guardians agree to follow all rules and safety protocols. Though sessions are carefully supervised, Valkyrie's Kindred Keep and any persons connected with it assume no liability for injury or accidents occurring on or off the premises.
3. The undersigned, as participant and/or as parent or guardian of the minor named below, agrees to hold harmless and indemnify Valkyrie's Kindred Keep, its officers, directors, trustees, agents, employees, volunteers, representatives, and successors from any and all liability, claims, demands, losses, causes of action, damages, or legal costs, including attorney's fees, arising out of participation in program activities.
4. I agree to follow all guidelines and safety instructions. I further agree to release and not hold liable Valkyrie's Kindred Keep or any associated persons or entities for any incident or injury that may occur in connection with this program.
5. This agreement is non-assignable and non-transferable, is governed by the laws of the State of California, and is intended to be as broad and inclusive as permitted by law.

Participant Name: _____

Guardian Name: _____

Address: _____

Telephone Number: _____

Signature

Print Name

Date

Relationship to Participant
(if not participant)



12. Program Policies

These policies are in place to support the safety and well-being of participants, volunteers, equines, staff, and visitors. In addition to the policies below, the facility maintains a strict 5 MPH speed limit near and on the property.

Fees, Payment & Scheduling Policy

- Current session options, lengths, and rates will be provided before scheduling or purchase.
- Payment is required prior to services. Payment may be made per session or through an available package.
- Session times are scheduled by appointment and are subject to current program availability. Weekday and weekend options may be available.

Enrollment & Attendance

- A completed intake packet is required before participation so the program can determine suitability and horse selection.
- The program requires two weeks' notice to be removed from the schedule without a cancellation fee. If two weeks' notice is not provided, a \$100 fee will apply.
- If a client misses three consecutive lessons with no notice, they may be removed from the schedule and no refund will be available.
- If a client must take medical leave, written release from the physician may be required before returning.
- Parents / guardians must remain in the observation area during the scheduled session. This includes siblings, guests, or other family members attending the session.

Missed Lesson Policy

- If you are more than 15 minutes late, the session will be cancelled.
- The program requires 24-hour notice for cancellations for the purpose of staff and volunteer scheduling.
- In case of inclement weather conditions (rain, high wind, heat, etc.) and mounted lessons cannot safely be performed, a horsemanship lesson may replace the mounted lesson. If a client chooses not to attend the horsemanship lesson, no make-up, refund, or credit will be provided.

Participant & Guest Attire

- For everyone's safety, all visitors and participants must wear closed-toe shoes. Visitors in open-toe shoes may go straight to the observation area but may not approach any equine.
- Boots with a hard sole and a 1/4-inch heel are recommended for all participants but are not required. Program staff determines the appropriateness of all footwear.
- Participants must wear long pants.
- Helmets are required for all participants riding or working near equines. Helmets can be supplied by the program, though families are encouraged to invest in their own ASTM / SEI approved helmet.



Activity & Workload Limits

- Activities and workload limits are individually set by program staff for each horse in the program.
- Horse selection is determined by many factors. At the sole determination of program staff, the most appropriate horse(s) will be matched with a participant.
- Weight and workload limits are individually set for each equine in the program. No equine in the program has a weight limit higher than 200 lbs.

Participant Dismissal

- Program staff reserves the right to dismiss or suspend a participant from services if safety guidelines are not followed, if staff determine participation is no longer appropriate, or if the participant's needs fall outside the program's current scope.

Initial here to indicate you have read and understand the program policies: _____

13. Photo Release & Signature

I give Valkyrie's Kindred Keep permission to take and have taken still or moving photographs of the participant, family, or guests at the facility. I also authorize Valkyrie's Kindred Keep to use such photographs in advertising, news media, brochures, website materials, and related program communications.

By signing below, I acknowledge that I have read and understand the above policies, releases, and forms.

_____	_____	_____	_____
Print Name	Signature	Date	Participant Name (if different from signer)

Relationship to Participant (if signed by someone other than participant):
