Dream Rider Equestrian Therapy

Client Registration & Release Form

Registration

Client: _____ Date of Birth____:_____
Age:_____ Address:_____ City:_____
State:_____ Zip:_____
Home Phone:_____Work:_____
Cell Phone:_____

Email:_____
Parents orGuardian/Partner/Spouse:_____
Address:_____
Home Phone:_____
Work:_____Cell Phone_____
Email:_____

In case of emergency
Contact:_____
Phone:_____
Contact:_____
Phone:_____

Photo Release

I hereby consent to and authorize the use and reproduction by Dream Rider Equestrian Therapy of any and all photographs and any other audiovisual materials taken of me/ my son/ my daughter/ my ward for promotional printed material, educational activities or for any other use for the benefit of the program.
Date:_____
Signature:_____
Client, Parent or Guardian

Non-Consent of Photo Release

I do not consent or authorize the use and reproduction by Dream Rider Equestrian Therapy of any photograph or audiovisual materials taken of me/my son/ my daughter/ my ward for promotional or printed material or for any other use.

Date:_____
Signature:_____
Client, Parent or Guardian

CLIENT RELEASE AND HOLD HARMLESS AGREEMENT

Dream Rider Equestrian Therapy provides therapeutic horseback riding for people with disabilities. Horseback riding is a risk exercise, so volunteers and horses are carefully selected and trained and safety equipment is required for all riders.

No client will be accepted for riding instruction and no volunteer, participants accepted for service until this form has been **READ, UNDERSTOOD, COMPLETED AND SIGNED** by the parent(s) or guardian(s) of a minor or by the client or volunteer if of legal age and sound mind.

Although participation in the **Dream Rider Equestrian Therapy** program is under strict supervision and every effort is made to avoid injury or accident, the undersigned acknowledges the inherent risks involved in riding and working around horses, including bodily injury from riding or being in close proximity to horses, among other risks, and further that both horse and rider can be injured in normal use, or schooling. In order to provide this valuable service, NO LIABILITY can be accepted by the **Dream Rider Equestrian Therapy** program, nor by any of the organizations or persons connected with the above-named facility.

IN CONSIDERATION for the privilege of riding and/or working around horses at the **Dream Rider Equestrian Therapy** program, the undersigned, as self or as parent or guardian of a minor participating in the program, jointly and severally do hereby agree to release, hold harmless and indemnify the **Dream Rider Equestrian Therapy** program, its officers, directors, trustees, agents, employees, representatives, successors and assigns, Catherine Hand, head instructor and president, from all manner of liability, loss, costs, claims, demands and damages of every kind and nature whatsoever, including, but not limited to reasonable attorneys' fees, which the undersigned or said minor may now or in the future have against the **Dream Rider Equestrian Therapy** program, its officers, directors, trustees, agents, employees, representatives, successors and assigns, on account any accident, damage, injury or illness, physical or mental condition, known or unknown, to the undersigned or said minor, or the treatment thereof, arising as a result of, or in any way connected to acts or incidents occurring at or relating to the **Dream Rider Equestrian Therapy** program, its officers, directors, trustees, agents, employees, representatives, successors and assigns, and Catherine Hand, president, including but not limited to their negligence or gross negligence in rendering services described above or in any way incidental thereto.

The undersigned further agrees to use only those facilities of Dream Rider Equestrian Therapy and will not remove horses or property from the facility without authorization of the management.

PARTICIPANT NAME (PLEASE PRINT)

_____ _____

PARENT/ GUARDIAN NAME (PLEASE PRINT) RELATIONSHIP TO PARTICIPANT

_____

SIGNER'S ADDRESS

_____

CITY STATE ZIP CODE

_____

_____

SIGNATURE: PARENT OR LEGAL GUARDIAN

_____

DATE _____

VOLUNTEER RELEASE AND HOLD HARMLESS AGREEMENT

Dream Rider Equestrian Therapy provides therapeutic horseback riding for people with disabilities. Horseback riding is a risk exercise, so volunteers and horses are carefully selected and trained and safety equipment is required for all riders.

No client will be accepted for riding instruction and no volunteer, participants accepted for service until this form has been **READ, UNDERSTOOD, COMPLETED AND SIGNED** by the parent(s) or guardian(s) of a minor or by the client or volunteer if of legal age and sound mind.

Although participation in the **Dream Rider Equestrian Therapy** program is under strict supervision and every effort is made to avoid injury or accident, the undersigned acknowledges the inherent risks involved in riding and working around horses, including bodily injury from riding or being in close proximity to horses, among other risks, and further that both horse and rider can be injured in normal use, or schooling. In order to provide this valuable service, NO LIABILITY can be accepted by the **Dream Rider Equestrian Therapy** program, nor by any of the organizations or persons connected with the above-named facility.

IN CONSIDERATION for the privilege of riding and/or working around horses at the **Dream Rider Equestrian Therapy** program, the undersigned, as self or as parent or guardian of a minor participating in the program, jointly and severally do hereby agree to release, hold harmless and indemnify the **Dream Rider Equestrian Therapy** program, its officers, directors, trustees, agents, employees, representatives, successors and assigns, Catherine Hand, head instructor and president, from all manner of liability, loss, costs, claims, demands and damages of every kind and nature whatsoever, including, but not limited to reasonable attorneys' fees, which the undersigned or said minor may now or in the future have against the **Dream Rider Equestrian Therapy** program, its officers, directors, trustees, agents, employees, representatives, successors and assigns, on account any accident, damage, injury or illness, physical or mental condition, known or unknown, to the undersigned or said minor, or the treatment thereof, arising as a result of, or in any way connected to acts or incidents occurring at or relating to the **Dream Rider Equestrian Therapy** program, its officers, directors, trustees, agents, employees, representatives, successors and assigns, and Catherine Hand, president, including but not limited to their negligence or gross negligence in rendering services described above or in any way incidental thereto.

The undersigned further agrees to use only those facilities of Dream Rider Equestrian Therapy and will not remove horses or property from the facility without authorization of the management.

VOLUNTEER'S NAME (PLEASE PRINT)

_____ _____

PARENT/ GUARDIAN/SPOUSE/PARTNER NAME (PLEASE PRINT) RELATIONSHIP TO VOLUNTEER

_____

SIGNER'S ADDRESS

_____

CITY STATE ZIP CODE

_____ _____

SIGNATURE: PARENT OR LEGAL GUARDIAN

_____

DATE _____

Client Authorization for Emergency Medical Treatment Form

In the event emergency treatment/medical aid is required due to illness/injury during the process of receiving services, or while being on the property of the agency, I authorize the Dream Rider Equestrian Therapy to:

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

Client's Name:
_____Phone:_____
Address: _____City: _____
Zip: _____
Allergies:_____

In the event I cannot be reached,

Contact:_____
Phone:_____
Contact: _____
Phone: _____
Physician's Name:
_____
Preferred Medical Facility:
_____
Health Insurance Co.: _____
Policy #: _____

Consent Plan

This authorization includes x-rays, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by a physician. This provision will only be invoked if the person is unable to be reached.

Date: _____
Consent Signature: _____
Client, Parent or Guardian (if under 18):
_____
Print name:
_____
Home Phone: _____ Work: _____
Cell: _____
Address: _____City: _____
Zip: _____

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 the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____
_____
_____
Client, Parent or Guardian (if under 18):
_____
Print Name:_____
Home Phone: _____Work: _____Cell:_____
Address: _____
City: _____Zip:_____

Client's Medical History and Physician's Statement

Please give to your doctor to complete
Please complete all sections

Name: _____
Date of Birth:_____
Address:_____
Name of Parent/Guardian/Partner/Spouse:_____
_____
Diagnosis:_____ **Date of Onset:**_____

- ***For persons with Down Syndrome:***

  - Negative Cervical X-ray for Atlantoaxial Instability. X-ray date_____
  - Negative for clinical symptoms of Atlantoaxial Instability.

Tetanus Shot: Yes No Date_____
Shunt: Yes No
Height _____ Weight_____
Seizure Type _____ Controlled_____
Date of last seizure_____
Medications:_____
Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	**Comments**
Auditory	
Visual	
Speech	
Cardiac	
Circulatory	
Pulmonary	
Neurological	
Muscular	
Orthopedic	
Allergies	
Learning Disability	
Mental Impairment	
Psychological Impairment	
Other	

Therapeutic Riding Program
Physical/Occupational Therapist Assessment

Please give this form to the PT/OT that the rider is working with on a regular basis. This information is helpful for our instructors.
Client: _____ Age:_____
Date:_____
Disability: _____

School/ Medical Center:
_____

Please answer the following in terms of goals/objectives etc. that you are striving to achieve with the client.
Short Term Goals:

Objectives:

Long Term Goals:

Degree of Coordination:

Area of Strength:

Any precautions: