Tri-State Therapeutic Riding Center

PARTICIPANT REGISTRATION FORM

Date :_____

Participant Name :_____ Birthdate: _____

Age:_____ Sex:_____ Weight: _____ **Please note, at this time we cannot accommodate riders over 200lbs*

Address:_____ City:_____State:_____Zip:_____

Email:_____ Name of School (if applicable):_____

Mother's name:_____ Employed by:_____

Father's name:_____ Employed by:_____

Home Phone #: _____ Mobile Phone #:_____

Brief description of disability *(if applicable):* _____

Enrolling in the following program(s):

___ Reinbow Riders ___ Mindful Program ___ Horses for Heroes

___ Silver Stirrups ___ Carriage Driving ___ Taking The Lead

Please let us know what the best times for you to attend lessons are so that we can get you scheduled with an instructor. When you have been paired with an instructor, we will contact you. Tri-State Therapeutic Riding Center is experiencing tremendous growth, so you may be placed on a waiting list.

Monday	Tuesday	Wednesday	Thursday	Friday	Sunday
__9:00	__9:00	__9:00	__9:00	__9:00	__9:00
__10:00	__10:00	__10:00	__10:00	__10:00	__10:00
__11:00	__11:00	__11:00	__11:00	__11:00	__11:00
__12:00	__12:00	__12:00	__12:00	__12:00	__12:00
__1:00	__1:00	__1:00	__1:00	__1:00	__1:00
__2:00	__2:00	__2:00	__2:00	__2:00	__2:00
__3:00	__3:00	__3:00	__3:00	__3:00	
__4:00	__4:00	__4:00	__4:00	__4:00	
__5:00	__5:00	__5:00	__5:00	__5:00	
__6:00	__6:00	__6:00	__6:00	__6:00	
__7:00	__7:00	__7:00	__7:00	__7:00	

RETURN THIS FORM AS SOON AS POSSIBLE

RIDER AUTHORIZATIONS

EMERGENCY CONTACT

Name:_____ Relationship:_____

Home Phone #: _____ Mobile Phone #:_____ Work Phone #:_____

Address: _____ City/State/Zip: _____

Physician:_____ Phone #:_____ Preferred Hospital:_____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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 Tri-State Therapeutic Riding Center to:

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

CONSENT FOR TREATMENT PLAN

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

☐ Yes, I consent ☐ No, I do not consent

Rider/Participant Signature:_____ Date:_____

Parent Signature (if under 18):_____ Date:_____

PHOTOGRAPHY CONSENT/NON-CONSENT

Tri-State Therapeutic Riding Center (TSTRC) often takes still pictures and/or videos of students, clients, volunteers and instructors. This is done for several reasons. Rider progress and acquisition of skills provide instructors and clients with necessary information and positive feedback. Photos/videos are also used in brochures, presentations, posters, and on our website for publicity. They are also occasionally provided to students for keepsakes. Please check one of the boxes below to indicate your preference for photograph/video of you/your child for the aforementioned purposes.

☐ Yes, I consent ☐ No, I do not consent

Rider/Participant Signature:_____ Date:_____

Parent Signature (if under 18):_____ Date:_____

LIABILITY RELEASE

To be completed by the adult participant, participant's parent, or participant's legal representative.

This release of liability is made and entered into on this date, _____(*MM/DD/YY),* by and between Tri-State Therapeutic Riding Center, hereinafter known as TSTRC, and staff/participant/volunteer *(print name),* _____ hereinafter known as participant. *If a minor or incompetent adult, please print participant's parent, legal guardian, or legal representative name:* _____. In return for participation in TSTRC's therapeutic horseback riding activities, special events and fundraisers, the participant, his/her heirs, assigns, and legal representatives hereby expressly agree to the following:

1. Participant agrees to assume any and all risks involved in or arising from participant's participation or presence upon the property and facilities, including, without limitation, but not limited to the risks of death, bodily injury, property damage, falls, kicks, bites, collisions with vehicles, horses, or stationary objects, fire or explosion, the unavailability of emergency medical care, or the negligence or deliberate act of another person.
2. Participant agrees to hold TSTRC and all of its successors, assigns, subsidiaries, franchisee, affiliates, officers, directors, employees, agents, and boarders completely harmless and not liable and release them from all liability whatsoever and agrees not to sue them on account of or in connection with any claims, causes of action, injuries, damages, costs or expenses arising out of participant's participation and/or presence upon TSTRC's property and facilities, including without limitation, those based on death, bodily injury, property damage, including consequential damages, except if the damages are caused by the direct willful and wanton negligence of TSTRC.
3. Participant agrees to waive the protection afforded by any statue or law in any jurisdiction whose purpose, substance and/or effect is to provide that a general release shall not extend to claims, material, or otherwise, which the person giving the release does not know or suspect to exist at the time of executing the release.
4. Participant agrees to indemnify and defend TSTRC against, and hold it harmless from, any and all claims, causes of action, damages, judgments, costs, or expenses, including attorney's fees, which in any way arise from participant's participation and/or presence upon TSTRC's property or facilities.
5. This contract is non-assignable and non-transferable and is made and entered into the State of Tennessee and shall be enforced and interpreted under the laws of this state. Should there be any clause in conflict with State Law, then that clause is null and void. When TSTRC and participant or participant's parent, legal guardian, or adult caregiver signs this contract, it will then be binding on both parties, subject to the above terms and conditions.

Participant/ Rider Signature:_____ Date:_____

Parent / Guardian Signature (if under 18):_____Date:_____

TSTRC Representative Signature:_____ Date:_____

CONFIDENTIALITY STATEMENT

Tri-State Therapeutic Riding Center will preserve the right of confidentiality for all individuals in its program. The staff and volunteers will keep confidential all medical, social, personal, and financial information regarding a person and their family. We ask all participants to preserve the right of confidentiality for all individuals observed in the program.

I understand and will observe the confidentiality policy of Tri-State Therapeutic Riding Center.

Rider Signature:_____ Date:_____

Parent Signature (if under 18):_____ Date:_____

Tri-State Therapeutic Riding Center

RIDER'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Must be completed annually

Name:_____ Birthdate:_____

Address:_____

Name of Parent(s)/Guardian(s): _____

Diagnosis:_____

Date of Onset:_____

For persons with Downs Syndrome Negative cervical x-ray for Atlantoaxial instability date:_____
Must be negative for clinical symptoms of Alantoaxial instability.

Height:_____ Weight:_____ ***Please note, we have a 200lb weight limit***

Tetanus Shot: __Yes __No Date:_____

Seizure Type:_____ Controlled:_____ Date of Last Seizure:_____

Medications:_____

Please indicate if participant has a history and/or has had surgeries in any of the following areas by checking yes or no. Make necessary comments.

Areas	***Yes***	***No***	***Comments***
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation __Yes __No Crutches __Yes __No Braces __Yes __No
Wheelchair __Yes __No

Please indicate any special precautions: _____

Tri-State Therapeutic Riding Center

PHYSICIAN'S STATEMENT

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Tri-State Therapeutic Riding Center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialled health professional (e.g. PT, OT, psychologist, etc.) in the implementation of an effective equestrian program.

Physician Name *(please print):*_____

Physician Signature:_____Date:_____

Address:_____ Phone #:_____

INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions or contraindications to the therapeutic horseback riding. Therefore, when completing this form, ***please CIRCLE whether these conditions are present and note to what degree.***

Allergies
Cancer
Chiari II Malformation
Coxas Arthrosis
Cranial Deficits
Diabetes
Hemophilia
Heterotopic ossification
Hip Subluxation and Discoloration
Hydrocephalus/shunt
Hydromyelia
Hypertension
Internal Spinal Stabilization Devices
Kyphosis
Lordosis
Medical/Surgical
Neurological
Orthopedic
Osteogenesis Imperfecta
Osteoporosis
Paralysis due to Spinal Cord Injury
Pathologic Fractures
Peripheral Vascular Disease
Poor Endurance
Recent Surgery
Scoliosis
Seizure Disorders
Serious Heart Condition
Spina Bifida
Spinal Fusion
Spinal Instabilities/Abnormalities
Spinal Orthoses
Stroke (Cerebrovascular Accident)
Tethered Cord
Varicose Veins

<u>Secondary Concerns</u>
Acute exacerbation of chronic disorder
Age 2-4 years
Age under 2 years
Behavior Problems
Indwelling catheter

Physician's Notes: _____
_____
_____

RIDER BACKGROUND AND BEHAVIOR EVALUATION

To best serve our riders, please fill out this form entirely.

Rider's Name:_____ Date:_____
Diagnosis:_____

To be completed by parent/guardian:
Does this rider participate in a behavioral support plan?_____

List behaviors to be discouraged and potential triggers:
_____
_____
_____

List coping skills or how the rider handles stressful situations:
_____
_____
_____

What is the main focus for treatment (short and long term goals)?
_____
_____
_____
_____

To be completed by instructor/therapist:
Therapist Name and Specialization: _____
Phone and/or email:_____

What are the short/long term goals for this individual?
_____
_____
_____

Specific treatment interventions to be used to work towards these goals:
_____
_____

Behavior patterns to be aware of:
_____
_____

(Please note, all information is confidential and kept in a locked filing cabinet onsite at the Tri-State Therapeutic Riding Center. Only instructors and parents can view these files upon request.)