



Rider's Registration & Release Form

Registration

Client: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

Email: _____

Parents or Guardian: _____

Address: _____

Home Phone: _____ Work/ Cell Phone: _____

Email: _____

School or Institution presently attending: _____

In case of emergency

Contact: _____

Phone: _____

Contact: _____

Phone: _____

Photo Release

I hereby consent to and authorize the use and reproduction by Cornerstone Therapeutic Riding Center 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



RELEASE AND HOLD HARMLESS AGREEMENT

Cornerstone Therapeutic Riding Center (CRTC) 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 student 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 student or volunteer if of legal age and sound mind.

Although participation in the **CRTC** 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 in competition and schooling. In order to provide this valuable service, **NO LIABILITY** can be accepted by the **CRTC** program or 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 **CRTC** 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 **CRTC** program, its officers, directors, trustees, agents, employees, representatives, successors and assigns, Creek Hollow Ranch and Colleen Burman, 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 **CRTC** 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 **CRTC** program, its officers, directors, trustees, agents, employees, representatives, successors and assigns, Creek Hollow Ranch and Colleen Burman, 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 Creek Hollow Ranch set aside for use by **CRTC**, and to stay away from the Creek Hollow Ranch horses and other property, unless accompanied by an authorized **CRTC** personnel.

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



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 Cornerstone Therapeutic Riding Center 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:

Date: _____ Non-Consent Signature: _____
Client, Parent or Guardian (if under 18): _____
Print Name: _____
Home Phone: _____ Work: _____ Cell: _____
Address: _____ City: _____ Zip: _____

Rider'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: _____

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			

Mobility: Independent Ambulation Yes No Crutches Yes No Braces Yes No Wheelchair Yes No

Please indicate any special precautions: _____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the 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/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician Name (please print) _____

Physician Signature _____

Address _____ City _____ State _____ Zip _____

Information for Physician

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

Orthopedic

Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation & Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices
Age under four years

Neurologic

Hydrocephalus/shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis due to Spinal Cord injury
Seizure Disorders

Medical/Surgical

Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident)

Secondary Concerns

Behavioral problems
Acute exacerbation of chronic disorder
Indwelling catheter

Additional requirement for Down's Syndrome

- 1) A medical exam with special reference to neurological function.
- 2) Lateral or side view x-rays (within the last five years) of the upper cervical region in full flexion and full extension
- 3) Certification from a physician that an exam did not reveal atlanto-axial instability or focal neurological disorder.



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: _____

Please answer the following in terms of goals/objectives etc. that you are striving to achieve with the student.

Short Term Goals:

Objectives:

Long Term Goals:

Degree of Coordination:

Area of Strength:

Any precautions:



CORNERSTONE THERAPEUTIC RIDING CENTER

Rider's Name: _____

Please indicate the hours that you are available to ride:

	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning					
Midday					
Afternoon					

I definitely can not ride the following days & and times:

Comments: _____

