## RIDER'S REGISTRATION & PHOTO RELEASE FORM

**Rider Registration**

Client:_______________ Date of Birth:__________ Age:__________

Address:_______________ City:__________ State:______ Zip:________

Home Phone:_______________ Work/Cell Phone:_______________

Email:_______________________________________

School or Institution presently attending:_______________________

---

Parents or Guardian (if applicable):_______________________

Address:_______________ City:__________ State:______ Zip:________

Home Phone:_______________ Work/ Cell Phone:_______________

Email:_______________________________________

---

**Emergency Contact**

Contact:_______________ Phone: __________ Relation:__________

Contact:_______________ Phone: __________ Relation:__________

---

**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:

☐ myself ☐ 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 **CTRC** 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 **CTRC** 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 **CTRC** 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 **CTRC** program, its officers, directors, trustees, agents, employees, representatives, successors and assigns, 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 **CTRC** 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 **CTRC** program, its officers, directors, trustees, agents, employees, representatives, successors and assigns, including but not limited to their negligence or gross negligence in rendering services described above or in any way incidental thereto.

______________________________________________

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:______________________________________ Phone:____________________________________
Address:____________________________________ City:______________ State:_______ Zip:_________
Allergies:_______________________________________________________________________________

**Emergency Contact**

Contact:____________________________________ Phone: _________________ Relation:___________
Contact:____________________________________ Phone: _________________ Relation:___________

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:______________________________________________________________________________
Phone(s): Home:_______________________ Work:___________________ Cell:____________________
Address:____________________________________ City:______________ State:_______ 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:____________________ Consent Signature:_____________________________________________
Client, Parent or Guardian (if under 18):__________________________________________________
Print name:______________________________________________________________________________
Phone(s): Home:_______________________ Work:___________________ Cell:____________________
Address:____________________________________ City:______________ State:_______ Zip:_________

# RIDER'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

**(Please give to your doctor to 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 | 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: ______________________

______________________

______________________

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
Scoliiosis
Kyphosis
Lordosis
Hip Subluxation & Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devises
Age under four years

**Secondary Concerns**
Behavioral problems
Acute exacerbation of chronic disorder
Indwelling catheter

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

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

**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: