Charleston Area Therapeutic Riding, Inc.
P.O. Box 146 • Johns Island, SC 29457-0146 • (843) 559-6040 • acain@catr-program.org

P1

RIDER'S REGISTRATION AND RELEASE FORM

Student:_____ Date of Birth: _____

Address: _____

City: _____State: _____ Zip Code: _____ Home

Phone: _____ Work Phone: _____ Cell: _____

Email: _____

Name of School, Institution or Employment: _____

Name of Parent or Guardian: _____

Address, City, State: _____ Phone: _____

In case of Emergency: Contact:_____ Phone: _____

LIABILITY RELEASE

_____ (client's name) would like to participate in the Charleston Area Therapeutic Riding, Inc. program. I acknowledge the risks and potential for risks of horseback riding. However, I feel the possible benefits to myself / my son / my daughter / my ward are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Charleston Area Therapeutic Riding, Inc.

_____ _____
Date Signature of Client, Parent or Guardian

PLEASE SIGN ONLY ONE CONSENT BELOW

PHOTO RELEASE
I hereby consent to and authorize the use and reproduction by Charleston Area Therapeutic Riding, Inc. of any and all photographs and any other audiovisual materials take 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 of Client, Parent or Guardian

NON-CONSENT
I do not consent to the use of photographs etc. as defined above.

_____ _____
Date Signature of Client, Parent or Guardian

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P2

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Student:_____ Date of Birth: _____
Address: _____
City: _____State: _____ Zip Code: _____ Home Phone: _____ Work Phone: _____ Cell: _____
Health Insurance Co: _____Policy #: _____
Allergies to Medications: _____
Current Medications: _____

In the event of an emergency, contact:
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____
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 Charleston Area Therapeutic Riding, Inc. 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.

PLEASE SIGN ONLY ONE CONSENT

CONSENT 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.

_____ _____
Date Participant, Parent or Legal Guardian

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 procedure to take place:
_____
_____
_____

_____ _____
Date Participant, Parent or Legal Guardian

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P3

Health History Form

GENERALINFORMATION

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____

Phone: _____ E-mail_____ Alternative #: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian/Caregivers: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

Phone: _____

How did you hear about the program? _____

HEALTH HISTORY

Diagnosis _____ Date of Onset:_____

Please indicate current or past special needs in the following areas:

	У	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

MEDICATIONS *(include prescription, over-the-counter; name, dose and frequency)*

Please describe abilities/difficulties in the following areas (include assistance required or equipment needed):

PHYSICAL FUNCTION *(i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)*

PSYCHO/SOCIAL FUNCTION *(i.e. Work/school including grade completed, leisure interests relationships-family structure, support systems, companion animals, fears/concerns, etc)*

GOALS *(i.e. What would you like the participant to accomplish?*

Signature of Student or Parent or Legal Guardian

Date

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P4

STUDENT MEDICAL HISTORY

Name: _____ Date of Birth: _____

Address: _____

Name of Parent or Guardian: _____

Diagnosis: _____ Date of Onset: _____

*** For persons with Down Syndrome****

And/Or □ Negative Cervical X-ray for Atlantoaxial Instability X-ray Date: _____

□ Negative for clinical symptoms of Atlantoaxial Instability

Tetanus Shot: □ Yes □ No Date: ____/____/____ Height: ____ '_____" Weight: _____lbs.

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.

Must be signed and dated by the student's physician.

Physician Name(please print): _____

Physician Signature: _____

Address, City, State, Zip: _____

Phone: ( ) _____ Fax: ( )_____ Date: _____

Please see other side →

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 and Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

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

Secondary Concerns

Behavior problems
Age under two years
Age two – four years
Acute exacerbation of chronic disorder
Indwelling catheter