R·E·A·C·H
THERAPEUTIC RIDING CENTER
Reach your potential!

Contact Information Update

Participant's Name: _____

Height: _____ Weight:_____ Age:_____

Has there been an address change for this participant?

Street/PO Box _____

City _____ Zip _____

Have there been any phone number changes? We sometimes need to notify our participants of a change in schedule**; please be sure that we have a current phone number for the person who will be responsible for the transportation of the participant.**

Primary Phone: _____ Relationship:_____

Secondary Phone: _____ Relationship:_____

Have there been any email address changes? We only use email to notify you of upcoming events at the barn. Please print clearly.

Email: NO: _____ YES:_____

Please list any changes at home and/or in school that would affect behavior at the barn:

AUTHORIZATION FOR EMERGENCY MEDICAL

Participant's Name: _____

Please Print

In case of Emergency, contact: _____ Phone(s): _____

Physician's Name: _____

City: _____ Phone: _____

Please indicate any allergies: _____

Please indicate any medical issues that may effect your/your child's participation at REACH. _____

_____

Date of last Tetanus shot: _____

CONSENT PLAN I give consent for emergency medical treatment/aid (including x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician) In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, any participation on my part at REACH, or while being on the property of REACH, I authorize REACH Therapeutic Riding Center to:

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

Participant Consent Signature _____ Date: _____

Signature of Parent/Guardian _____

(If participant is under 18 years of age)

~~~ **OR** ~~~

NON-CONSENT PLAN

I do not give consent for emergency medical treatment/aid in the event of illness or injury during the process of receiving services, any participation on my part at REACH, or while being on the property of REACH. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

Participant Signature _____ Date: _____

Signature of Parent/Guardian _____

(If participant is under 18 years of age
~~~

PHOTO RELEASE

____ **I consent** to and authorize ____ I **do not** consent to nor do I authorize the use and reproduction by REACH of any and all photographs and any other audiovisual materials taken of me or my child for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the program.

Name _____

Participant Signature _____ Date: _____

Signature of Parent/Guardian _____
(If participant is under 18 years of age)

POLICY OF CONFIDENTIALITY

I agree to respect and observe privacy and confidentiality of the participants, volunteers and donors of REACH Therapeutic Riding Center and not discuss or disclose any sensitive information about any person or their family.

Name _____

Participant Signature _____ Date: _____

Signature of Parent/Guardian _____
(If participant is under 18 years of age)

LIABILITY RELEASE

That I, _____ or that I, the undersigned parent or legal guardian of _____, a minor, for and in sole consideration of the privilege of permitting said person to participate in activities at or sponsored by REACH Therapeutic Riding Center (RTRC) and recognizing that horseback riding activities involve certain inherent dangers and risks to persons and property, do hereby agree to assume for myself and on behalf of my ward or child, the risks and dangers attendant to such activity, including but not limited to: falling or being thrown from a horse, being kicked, stepped on or bitten by a horse or other animal, and/or injuries sustained while riding, mounting or dismounting a horse. I further acknowledge the risks and potential for risks associated with recreational and outdoor activities, including but not limited to: snake, animal or insect bites; uneven ground; sun, cold and wind exposure; cuts and scrapes; sore or pulled muscles; broken, dislocated or fractured bones; nerve damage; internal injuries; head injuries; grievous bodily injury or death. However, I feel that the possible benefits to myself, child or ward are greater than the risk assumed.

I hereby, intending to be legally bound, for myself and my child or ward, heirs and assigns, executors or administrator, waive and forever release, acquit, discharge and hold harmless all claims for damages against RTRC, its board of directors, trustees, agents, instructors, therapists, employees, representatives, volunteers, owners of property on which RTRC operates, successors or assigns on account of any personal injuries and/or personal damages known or unknown, or in anyway growing out of, the acts of RTRC, its board of directors, trustees, agents, instructors, therapists, aids, employees, representatives, volunteers, owners of property on which RTRC operates, successors or assigns.

WARNING

I understand that under Texas Equine Liability Act (Chapter 87, Civil Practice and Remedies Code), an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities.

I, the undersigned, have read this waiver of liability in its entirety. I understand the terms of this release and have signed this release voluntarily and with full knowledge of the effects thereof.

Participant Signature _____ Date: _____

Signature of Parent/Guardian _____

(If participant is under 18 years of age)

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PHYSICIAN ASSESSMENT & PERMISSION

~~To be completed by physician~~

Client's Name: _____ Date of Birth: _____

Diagnosis:

Primary: _____ Date of Onset: _____

Secondary: _____ Date of Onset: _____

Other: _____ Date of Onset: _____

Past/Prospective Surgeries _____

_____

_____

Medications _____

_____

Seizures: _____No _____ _____Yes Type: _____ Date of last seizure: _____

Shunts, Implants: _____

Mobility: Independent Ambulation: ____ Yes _____No Assisting Devices: _____

_____

In order to safely provide this service, REACH requests that you please note that the following conditions may suggest precautions and contraindications to equestrian activities. Therefore, when completing this form, please indicate whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability - include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizures
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other
Indwelling Catheters/Medical Equipment
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Client's name: _____

As thoroughly as possible, please indicate current or past difficulties/symptoms in the following systems/areas that apply including surgeries.

Area	No	Yes	Degree/ Comments
Auditory			
Visual			
Speech			
Tactile/Sensory			
Cardiac			
Circulatory			
Pulmonary			
Integumentary/Skin			
Immunity			
Neurologic			
Muscular			
Orthopedic			
Bowel/Bladder			
Learning Disabilities			
Cognitive			
Emotional/Psychological			
Behavior			
Other			

<u>For those with Down Syndrome</u>:

An Altlantoaxial x-ray and annual exam to exclude Atlantoaxial instability is required for clients with Down Syndrome over the age of 3. Date of X-Ray:_____ Results: _____

Neurologic Symptoms of Atlantoaxial instability: _____

_____

Given the above diagnosis and medical information, this person is not medically precluded from participation in supervised equestrian activities. I understand that REACH Therapeutic Riding Center will weigh the medical information indicated above against any existing precautions and/or contraindications before accepting this person for therapeutic horseback riding lessons. Therefore, I refer this person to REACH for ongoing evaluation to determine eligibility for participation.

Name/Title:_____ MD, DO, NP, PA Other _____

Signature: _____ Date:_____

Address: _____

_____

Phone: _____ License/UPIN Number:_____