30 Martin Drive Reinholds, PA 17569

Participant's Registration and Release Form

Client:_____Date of Birth:_____Age:_____

Street:_____City:_____State:_____Zip:_____

Phone: Home:_____Work _____Emergency:_____

Parent/Guardian Name:_____

Address/Phone:_____

School or institution presently attending:_____

In case of emergency contact:_____Phone:_____

contact:_____Phone:_____

Liability Release

I, _____(Client's Name) would like to participate in The Triangle Therapeutic Riding Center, Inc. Program.. I acknowledge the risks and potential for risks of being around horses. However, I feel that the possible benefits to myself/ my child/ my ward are greater than the risk 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 The Triangle Therapeutic Riding Center, Inc. & Stony Run Fields, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my child/my ward may sustain while participating in The Triangle Therapeutic Riding Center, Inc. Program and on the facility at Stony Run Fields.

Date:_____ Signature:_____
(Participant or Parent/Guardian)

Photo Release

I hereby consent to and authorize the use and reproduction by The Triangle Therapeutic Riding Center, Inc. of any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Date:_____ Signature:_____
(Participant or Parent/Guardian)

TRIANGLE
THERAPEUTIC RIDING CENTER, INC
30 Martin Drive Reinholds, PA 17569

Physician's Prescription

Participant's Name:_____Phone:_____

Prescription for Therapeutic Horseback Riding

Prescription for evaluation and treatment by a Physical, Occupational and/or Speech Therapist, or mental health professional in conjunction with The Triangle Therapeutic Riding Center, Inc.

Recommended Frequency:_____

Precautions:_____

_____

_____

_____

_____

Physician's Signature:_____Date:_____

Please Print, Type or Stamp

Physician's Name:_____

Address:_____

_____

_____

Phone:_____

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Participant Medical History and Physician's Statement

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: (Circle one) Yes / No **Date:**_____ **Height**_____**Weight:**_____

Seizure Type _____ Controlled_____Date of Last Seizure:_____

Please check if patient has a problem or surgeries in any of the following. If yes, please comment.

Areas	**Yes**	**No**	**Comment**
Allergies			
Auditory			
Cardiac			
Circulatory			
Learning Disability			
Mental Impairment			
Muscular			
Neurological			

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Areas	Yes	No	Comment
Orthopedic			
Psychological Impairment			
Pulmonary			
Speech			
Visual			
Other			

Mobility: *Independent Ambulation* Y/N *Crutches* Y/N *Braces* Y/ N *Wheelchair* Y/ N

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_____

Phone ( )_____ Date_____

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 _____

❑ Atlantoaxial Instabilities _____

❑ Scoliosis _____

❑ Kyphosis _____

Medical/Surgical

❑ Allergies _____

❑ Cancer _____

❑ Poor Endurance _____

❑ Recent Surgery _____

❑ Diabetes _____

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Participant's 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 ***The Triangle Therapeutic Riding Center, Inc*** to:

_X_ Secure and retain medical treatment and transportation if needed.

_X_ Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment at my expense.

I hold the Triangle Therapeutic Riding Center, Inc. harmless for any expenses incurred in my interests.

Name:_____ Phone:_____

Address:_____

Emergency Contact: _____ Phone: _____

Physician's Name and Phone:_____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Phone: _____

Policy #: _____ Group #: _____

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 below is unable to be reached.

Print Name: _____ Phone: _____

Address:_____

Consent Signature:_____ Date: _____

(Participant or Parent/Legal Guardian)

THERAPEUTIC RIDING CENTER, INC

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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:

_____

_____

_____

_____

_____

Non-Consent Signature:_____ Date: _____

(Participant or Parent/Legal Guardian)

Print Name: _____ Phone:_____

Address:_____

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM.