THERAPEION THERAPEUTIC RIDING CENTER
PARTICIPANT APPLICATION & HEALTH HISTORY
the minimum age for participation is four years old

Date:_____________________ Date of Birth: _________________ Age:________________
Name:____ Nickname: ____________________
Address:____
City ____ State: ________ Zip:___________
Cell phone: (_____)____________________Home phone: (____)______________________
Email address: ____
If under 18 years old, Parent or Guardian:____
Address, if different from above:____
City ____ State: ________Zip:____________
Cell phone: (_____)____________________ Home phone: (____)______________________
Email address: ____
If you are a student, school name: ____
School phone number: (_____)_____________ Principal's name:______________________
Occupation: _______________________ Employer:_________________________________
Work phone: (____)______________ May we call you at work? Yes No

IN CASE OF EMERGENCY

Contact name:__________________________________ Phone #: (_______)________________
Contact name:__________________________________ Phone #: (_______)________________

LIABILITY RELEASE

Indiana State Equine Laws states that: *Under Indiana law, 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.*

___________________________________ (Participant's name) would like to participate in the Therapeion Therapeutic Riding Center Program. I acknowledge the risks and potential for risks of horseback Riding and equine activities. However, I feel that the possible benefits to myself/my son/my daughter/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 to damages against Therapeion Therapeutic Riding Center, Inc, its Board of Directors, Instructors, Therapists, Aides, Volunteers, Employees, Stable Owners, and/or Stable Employees, as well as for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating at Therapeion Therapeutic Riding Center, Inc..

Date:_______________ Signature:____
Parent, Guardian, or Client (if client is over 18 years of age)
Print name:____

PHOTO RELEASE

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

Date:_______________ Signature:____
Parent, Guardian, or Client (if client is over 18 years of age)

PHOTO NON-CONSENT SIGNATURE

Date:_______________ Signature:____
Parent, Guardian, or Client (if client is over 18 years of age)

THIS FORM IS TO BE UPDATED ANNUALLY

THERAPEION THERAPEUTIC RIDING CENTER
Authorization for Emergency Medical Treatment

Emergency Information

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 Therapeion Therapeutic Riding Center to secure medical treatment and/or emergency transportation if needed and to release participant's records upon request to the authorized individual or agency involved in the medical emergency treatment.

Client name:____
Emergency Contact Information:
Name:________________________________ Relationship: __________________________
Cell phone: (____)____________________ Home phone: (____)______________________
Work phone: (____)____________________
Your Doctor Information:
Name: _______________________________ Phone: (_____)________________________
City: ________________________________ State:________________ ZIP:______________
Hospital:______________________________ City: __________________________________

CONSENT

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure. deemed lifesaving by the physician. This provision will ONLY be invoked if the person listed as the emergency contact is unable to be reached.
Consent Signature: ____ Date:____________
Parent, Guardian, or Client (if client is over 18 years of age)
Print name: ____

NON-CONSENT

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 Therapeion Therapeutic Riding Center. In the event emergency treatment aid is required, I wish the following procedures to take place:
____
____
Non-Consent Signature: _______________________________________ Date:_______________
Parent, Guardian, or Client (if client is over 18 years of age)
Print name: ____
Address:____
City:_______________________________________ State:______________ ZIP:____________

DISMISSAL POLICY: you will receive an information letter that contains our dismissal policy.
Dismissal of a participant will be considered if the participant exceeds our weight limit or if they are determined by a PATH Intl Instructor to potentially be a danger to themselves, our staff, or our equines or they violate the barn rules.
Dismissal of a family member/caregiver/guardian will be considered if they violate the barn rules or a PATH Intl Instructor determines they could potentially be a danger to themselves, our staff, or our equines.
All dismissals will be in written form.

THIS FORM IS TO BE UPDATED ANNUALLY

THERAPEION THERAPEUTIC RIDING CENTER
HEALTH HISTORY/PHYSICIAN RELEASE
ALL PAGES OF THIS FORM MUST BE UPDATED ANNUALLY by THE PHYSICIAN'S OFFICE

Form Completion Date:_______________ Participants Date of Birth: ______________________
Name:____
Address:____
City ____ State: ________Zip:_____________
Name of Parent or Guardian:____
Diagnosis:____
____
Medication names and doses: ____
____
Allergies: ____
Tetanus Shot Current? Yes No
Height ________ **Weight** ________ (*clients over 180 pounds may not be able to ride due to safety factors)*

**********FOR PERSONS WITH DOWNS SYNDROME***********

Full flexion and extension X-rays for Atlantoaxial Instability (AAI) is required within 5 years prior to entering Therapeion Therapeutic Riding Center s program. Annual physical examination should reveal no symptoms of AAI. Follow up X-rays should be every 10 years after.
NO INDIVIDUAL MAY RIDE WITH POSITIVE SYMPTOMS OF AAI.
Cervical X-ray for AAI Negative _________ Date _____________ Doctor's Initials _______

MEDICAL HISTORY
Please circle **Yes** *or* **No** *for each of the following conditions. The presence of a condition will need to be further evaluated before it is determined if it is appropriate for the client to receive riding instruction. This is for the client's safety.*

Spinal Fusion Yes No Location and type____

Past/Prospective Surgeries: ____
____
____

Medications: ____

Seizure Type: ____
Controlled: Y N Date of Last Seizure:____________

Shunt Present: Y N Date of last revision: ___________________________________
Special Precautions/Needs: ____
____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices: ____

THERAPEION THERAPEUTIC RIDING CENTER
HEALTH HISTORY/PHYSICIAN RELEASE
Page two

Participants Name:____

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

My signature indicates I have found no medical reason that this individual can not participate in Therapeion's programs.

Name/Title: ____MD DO NP PA Other ___________

Signature: ____Date: _________________

Address: ____

Phone (_______) ____________________________ License/UPIN Number: ________________________

During riding activities all riders are required to wear boots or shoes with a ½" heel. Please indicate below if this individual should be exempt from this rule because their braces or other physical issue prevent them from wearing any shoes except tennis/athletic type shoes.

____

Signature ____ Date __________________________