



Participant Registration & Release Forms

Participant's Last Name: _____ First Name: _____ Date of Birth: _____

Street Address: _____ City: _____ Zip: _____

County: _____ Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____ Email Address: _____

Name of Parent/Guardian: _____

Parent/Guardian's Cell Phone: (____) _____ Parent/Guardian's Work Phone: (____) _____

Parent/Guardian's Place of Employment: _____ City: _____

Participant's Ethnicity: _____ Gender: _____ Weight: _____ Height: _____

Primary Disability: _____ Other Disabilities: _____

Adaptations: _____

Has this person ever ridden a horse? Circle: YES or NO

List of activities, sports, games, and/or reinforcements that the participant enjoys:

List of activities, sports, games, objects etc. that the participant dislikes/fears:

Physical Abilities (Mobility, transfer skills, walking): _____

Psycho/Social Abilities: _____

What benefits would you like to obtain through HGR's programs & services? List goals here:

Photo Release

(Please check one):

I do _____ / I do NOT _____ consent to and authorize the use and reproduction by Heaven's Gait Ranch of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions, or for any other use for the benefit of the organization.

Signature _____ Date: _____

(Participant, Parent or Guardian)



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Liability Release

_____ (Participant's Name) would like to participate in the therapeutic riding program at Heaven's Gait Ranch. I acknowledge the risks and potential for risks of horseback riding. However, I feel the possible benefits of 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 for damages against Heaven's Gait Ranch, Inc., its Board of Directors, Instructors, Trainers, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in programs at Heaven's Gait Ranch.

Signature: _____ Date: _____
(Client, Parent or Guardian)

Rider's Authorization/Emergency Medical Treatment

In the event of an emergency that 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 Heaven's Gait Ranch to do the following: secure and retain medical treatment and transportation if needed and release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Emergency Contact Numbers

Primary Contact in case of emergency: _____ Phone: _____
Secondary Contact in case of emergency: _____ Phone: _____
Physician's Name: _____ Phone: _____
Preferred Medical Facility: _____ City: _____
Health Insurance Co: _____ Policy #: _____

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 emergency contacts are unable to be reached.

Date: _____ Print Name: _____ Phone: _____

Consent Signature: _____
(Participant, Parent or Guardian if Participant is under 18 years old)



Heaven's Gait Ranch, Inc.

Therapeutic Riding Center

2021

Dear Health Care Provider:

Your patient _____

(Participant's Name)

is interested in participating in programs and/or services at Heaven's Gait Ranch, Inc. In order to safely provide our services under the Professional Association of Therapeutic Horsemanship (PATH Intl.), our center requests that you complete the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to mounted activities and/or therapeutic horseback riding.

Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic	Medical/Psychological
Atlantoaxial Instability (include neurologic symptoms)	Allergies
Coxarthrosis	Animal Abuse
Cranial Defects	Cardiac Condition
Heterotopic Ossification/Myositis Ossificans	Physical/Sexual/Emotional Abuse
Joint subluxation/dislocation	Blood Pressure Control
Osteoporosis	Dangerous to Self or Others
Pathologic Fractures	Exacerbations of Medical Conditions (e.g., RA, MS)
Spinal Joint Fusion/Fixation	Fire Setting
Spinal Joint Instability/Abnormalities	Hemophilia
Neurologic:	Medical Instability
Hydrocephalus/Shunt	Migraines
Seizure	PVD
Sensory Deficit	Respiratory Compromise
Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia	Recent Surgeries
Other:	Substance Abuse
Age (under 4 years)	Thought Control Disorders
Indwelling Catheters/Medical Equipment	Weight Control Disorder
Medications (e.g., photosensitivity)	
Poor Endurance	
Skin Breakdown	



Participant's Medical History & Physician's Statement

***Note: The participant's physician must complete this form.**

Participant's Name: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Primary Diagnosis: _____ Date of Onset: _____

Current Status: _____

Secondary Diagnosis: _____ Date of Onset: _____

Current Status: _____

Past Surgeries: _____ Date: _____

Prospective Surgeries: _____ Date: _____

Medications (include prescription and over-the-counter, name, dose, and frequency):

Side Effects: _____

Does this participant have a history of seizures? Yes: _____ No: _____

If yes, please provide the following information.

Triggers: _____ Type of Seizure: _____

Controlled: Yes: _____ No: _____ Date of Last Seizure: _____

Shunt Present: Yes: _____ No: _____ Date of last revision: _____

Special Precautions/Needs: _____

Mobility Assessment:

Independent Ambulation: Yes: _____ No: _____

Assisted Ambulation: Yes: _____ No: _____

Wheelchair: Yes: _____ No: _____

Braces/Assistive Devices: _____



Participant's Medical History & Physician's Statement

***Note: The participant's physician must complete this form.**

Please complete the following chart based on your knowledge of this participant.

Does the participant have a history of concerns in the following areas? Indicate yes or no. Add comments to explain.

Category	Yes	No	Comments	Category	Yes	No	Comments
Auditory				Muscular			
Visual				Balance			
Tactile Sensation				Orthopedic			
Speech				Allergies			
Cardiac				Learning Disability			
Circulatory				Cognitive			
Integumentary/Skin				Emotional			
Immunity				Psychological			
Pulmonary				Pain			
Neurologic				Other			

Additional Comments:

Physician's Statement

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities. I understand that the PATH International center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH International center for ongoing evaluation to determine eligibility for participation.

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

Signature: _____ Date: _____

Address: _____

Phone: (____) _____ EXT _____ License/UPIN Number: _____