Heaven's Gait Ranch
Therapeutic Riding Center

Rider Registration & Release Forms

Rider's Last Name: ____________________ First Name:_________________ Date of Birth: ________

Street Address: ________________________________ City: ________________________ Zip: ______

County: _____________________ Home Phone: (____)____________ Cell Phone: (____)___________

Work Phone: (____)___________ Email Address: ____

Name of Rider's Parent/Guardian: ____

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

Parent/Guardian's Place of Employment: ______________________________ City: _______________

Rider'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 rider enjoys: _____________________

____

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

____

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

____

Psycho/Social Abilities: ____

____

What benefits would you like to obtain through riding? 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 program.

Signature ____ Date: ________________

(Client, Parent or Guardian)

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Liability Release

_______________________(Rider'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, its Board of Directors, Instructors, 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 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 the person below is unable to be reached.

Date: _____________ Print Name: ___________________________ Phone: ___________________

Consent Signature: ____
(Client, Parent or Guardian)

Heaven's Gait Ranch
Therapeutic Riding Center

Dear Health Care Provider:

Your patient____
(Participant's Name)
is interested in participating in therapeutic riding at Heaven's Gait Ranch, Therapeutic Riding Center. In order to safely provide this service 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 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	

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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: ____

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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: _________________