Beyond Limits Therapeutic Riding, Inc.

2017 Rider Application

Instructions for Therapeutic Riding Application

The following forms are to be filled out by the following persons:

Page 1 – Instructions

Page 2 – Participant or Parent/Guardian

Page 3 – Participant or Parent/Guardian

Page 4 – Participant or Parent/Guardian

Page 5 - Participant or Parent/Guardian

Page 6 – Participant or Parent/Guardian

Page 7 – Participant or Parent/Guardian

Page 8 – Physician

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Page 10- Physician

All forms must be completed in their entirety and submitted to Beyond Limits Riding prior to the first session.

2017 Participant's Registration and Release Form

Participant: _____ Date of Birth: _____

Street: _____City: _____Zip: _____

Phone: Home: _____Cell: _____Email: _____

School Presently Attending: _____

Parent/Guardian

Name: _____

Street: _____City: _____Zip: _____

Phone: Home: _____Cell: _____Email: _____

In Case of Emergency

Contact: _____Relation: _____Phone: _____

Contact: _____Relation: _____Phone: _____

PHOTO/VIDEO RELEASE

Name of Participant: _____

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants BLTR permission to take, or have taken, still and moving photographs and films of the above named Participant, including television pictures, and consents and authorizes BLTR, its advertising agencies, news media, and any other persons interested in BLTR and its work, to use and reproduce the photographs, films or pictures, and to circulate and publicize the same by all means, including, without limiting the generality of the foregoing, newspapers, television media, brochures, pamphlets, instructional materials, books, and clinical materials. With respect to the foregoing matters, no inducements or promises have been made to secure this signature to this release other than the intention of BLTR to use, or cause to be used, such photographs, films, and pictures for the primary purpose of promoting BLTR and its work.

I **GIVE** consent: _____**Date**: _____
Signature of adult Participant, or parent/guardian of minor Participant

I DO NOT give consent: _____**Date:** _____
Signature of adult Participant, or parent/guardian/ of minor Participant

Beyond Limits Therapeutic Riding, Inc.

Release of Liability 2017

Name of Rider and/or Volunteer:_____

Beyond Limits Therapeutic Riding, Inc., (BLTR) its officers, members, employees, instructors, and agents (including other riders) will not be responsible for any damages to person, animal or property at BLTR facility or its grounds or at any BLTR activities at other locations. Nor will BLTR be responsible for any property lost, damaged or destroyed. The undersigned rider and/or volunteer or parent/guardian hereby releases BLTR, its officers, members, employees, instructors and agents from ANY and ALL liability and claims of any nature whatsoever including taking any action to control, restrain, or confine the undersigned, for the safety or protection of the undersigned or others and any damages whatsoever (including costs, expenses and attorney's fees) that might result from damages, injuries or losses to their person or property during, or in connection with, or arising out of any volunteer activities, rider work, class, lesson, demonstration, show, clinic, event, function or any activity whatsoever, whether or not such damages, injuries or losses result directly or indirectly from the negligent act or omission or of any intentional or willful act or tort of such released parties or of any invitee of any released party.

WARNING: UNDER GEORGIA LAW, ANY EQUINE ACTIVITY SPONSOR OR EQUINE ACTIVITY PROFRESSONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE OR ANIMAL ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES, PURSUANT TO CHAPTER 12 OF TITLE 4 OF THE OFFICAL CODE OF GEORGIA ANNOTATED.

I have read and understand the Georgia Equine Liability Law. I agree that my use of the premises, and any animals, facilities or equipment is at my OWN risk. I further agree to indemnify and hold harmless BLTR, its respective officers, any and all property owners, employees, volunteers and tenants harmless from any and all suits, actions, costs, claims and liabilities of any kind arriving out of my use of the facility, premises, or participation in an equine activity, any animal activities at the facility or at another location with facility animals, any horse, dog, pony, cat, or animal on the property, living at visiting or boarding at the facility or of such use or participation by my guest, whether or not such claims result directly or indirectly from negligent act or omissions of the indemnified parties or otherwise. As a consideration for my visiting the facility or any BLTR Inc. activities at other locations, I assume any risk of damage to property, animal, injury or death to myself, or anyone visiting the facility with me. I understand there are certain risks inherent with handling animals and I accept those risks. I also acknowledge that horseback riding, and any involvement with horses, is a high-risk activity. I am participating at my own risk. I have read this agreement and fully understand its content.

AGREED:_____Date:_____

_____

Signature of adult rider and/or volunteer, or parent/guardian of minor rider and/or volunteer

2017 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 Beyond Limits Therapeutic Riding, Inc. to:

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

I hold Beyond Limits Therapeutic Riding, Inc. harmless for any expenses incurred in my interests.

Participant:_____

Emergency Contact #1:_____Phone:_____

Emergency Contact #2:_____ Phone:_____

Physician's Name: _____ Phone: _____

Dentist Name:_____ Phone:_____

Preferred Medical Facility: _____

Health Insurance Carrier: _____ Policy #:_____

Date of last Tetanus shot: _____

Please indicate any allergies:

_____

Please indicate any disability, limitations or medical conditions that may affect your riding lessons that we should be aware of:

_____

CONSENT PLAN (to be invoked in the event that your Emergency Contact cannot be reached) 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 of illness or injury while on the property of the agency. The undersigned hereby agrees to pay all fees and expenses of doctors, hospitals, ambulances and any other medical or dental expenses incurred.

Print Name: _____ Phone: _____

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

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 if over 18 or Parent/Legal Guardian

Print Name: _____ Phone: _____

2017 PARTICIPANT HEALTH HISTORY

Participant: _____ Date of Birth: _____

Health History

Please describe you/your child's current health status, particularly regarding the physical/emotional demands of participating in an equine program. Specify if there are issues with fitness, cardiac, respiratory, bone or joint function, recent hospitalizations or surgeries.

Height: _____ Weight: _____

_____

_____

Allergies (Medications, Food, Environmental (e.g. bees, horses, hay, grasses etc…)

_____

_____

Current Medications (Any side effects: behavior, energy level, sun exposure etc…)

_____

_____

I give my permission for Beyond Limits Therapeutic Riding, Inc. staff to give allergy medicine (such as Benadryl) to my child, if they are exhibiting signs of an allergic reaction to the horses or the stable environment.

Yes_____ No_____

Signature: _____ Date: _____
(Participant if over 18 or Parent/Guardian)

Participant's Consent for Release of Information

I hereby authorize Beyond Limits Therapeutic Riding, Inc. to release information from the records of Participant's Name _____DOB_____ for the purpose of developing a Riding Program for the above named participant. The information to be released is indicated below.

____ Medical History

____ Physical Therapy evaluation, assessment and program plan

____ Occupational Therapy evaluation, assessment and program plan

____ Speech Therapy evaluation, assessment and program plan

____ Mental Health diagnosis and treatment plan

____ Individual Habilitation Plan (I.H.P)

____ Classroom Individual Education Plan (I.E.P.)

____ Psychosocial evaluation, assessment, and program plan

____ Cognitive-Behavioral Management Plan

____ Other:_____

Signature: _____ Date: _____
(Participant if over 18 or Parent/Guardian)

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**:_____

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.

- ☐ Allergies
- ☐ Auditory
- ☐ Cardiac
- ☐ Circulatory
- ☐ Learning Disability
- ☐ Mental Impairment
- ☐ Muscular
- ☐ Neurological
- ☐ 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

_____

_____

_____

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 Medical/Surgical

❑ Spinal Fusion _____ ❑ Allergies _____

❑ Spinal Instabilities _____ ❑ Cancer _____

❑ Atlantoaxial Instabilities _____ ❑ Poor Endurance_____

❑ Scoliosis _____ ❑ Recent Surgery _____

❑ Kyphosis _____ ❑ Diabetes _____

Orthopedic Medical/Surgical

❑ Lordosis _____ ❑ Peripheral Vascular Disease _____

❑ Hip Subluxation and Dislocation _____❑ Varicose Veins _____

❑ Osteoporosis _____❑ Hemophilia _____

❑ Pathologic Fractures _____❑ Hypertension _____

❑ Coxas Athrosis _____ ❑ Serious Heart Condition _____

❑ Heterotopic Ossification _____❑ Stroke _____

❑ Osteogenesis Imperfecta _____

❑ Cranial Deficits _____

❑ Spinal Orthoses _____

❑ Internal Orthoses _____

❑ Internal Spinal Stabilization Devices _____

Neurologic Secondary Concerns

❑ Hydrocephalus/shunt _____❑ Behavior problems_____

❑ Spina Bifida _____❑ Age under two years _____

❑ Tethered Cord _____ ❑ Age two-four years _____

❑ Chiari II Malformation _____ ❑ Acute exacerbation of chronic disorder ____

❑ Hydromyelia_____ ❑ Indwelling catheter _____

❑ Paralysis due to Spinal Cord Injury _____

❑ Seizure Disorders _____

Beyond Limits Therapeutic Riding, Inc.
Physician's Referral

Participant's Name:_____Phone:_____

Referral for Therapeutic Horseback Riding

This is a referral for evaluation and treatment by a Therapeutic Riding Instructor, or mental health professional in conjunction with Beyond Limits Therapeutic Riding, Inc. Recommended Therapeutic Riding Program Frequency to be determined by Riding Instructor:

Precautions

_____

Physician's Signature: _____Date: _____

Please Print, Type or Stamp Physician's

Name _____

Address_____

Phone_____ Fax _____

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 Therapeutic Riding Instructor in the implementing of an effective equestrian program.

Physician Name (please print)_____

Physician Signature _____

Address _____ City_____ State___Zip_____

Phone (____)_____ Date_____