BARABOO RIVER EQUINE-ASSISTED THERAPIES, INC.

Rider Registration

Name_____Birthdate_____

Address_____Home Phone_____

City, State, Zip_____Cell Phone_____

E-mail_____

Name of Spouse, Parent or Guardian_____

IF UNDER 18 YEARS OF AGE, COMPLETE THE FOLLOWING:

Name of School_____

Name of Parent/Guardian_____Employer_____

Address_____Work Phone_____

City, State, Zip_____

_____

EMERGENCY CONTACT

Name_____Phone_____

Relationship_____Cell_____

Are you currently enrolled in:

Physical Therapy ( ) Yes ( ) No

Occupational Therapy ( ) Yes ( ) No

Speech Therapy ( ) Yes ( ) No

Explain therapy involvement_____

_____

_____

_____

_____

_____

_____

HOW DID YOU HEAR ABOUT BARABOO RIVER EQUINE-ASSISTED THERAPIES, INC.?

( ) Newspaper ( ) Radio/TV ( ) Poster ( )Volunteer ( ) Another Organization ( ) Other_____

HAVE YOU RIDDEN A HORSE BEFORE? ( ) YES ( ) NO

ARE YOU WILLING TO ATTEND EVERY CLASS? ( ) YES ( ) NO

IS THERE A PARENT, GUARDIAN, SIBLING, OR OTHER PERSON INTERESTED IN HELPING DURING THE RIDER'S CLASS TIME? IF SO, NAME_____

ADDITIONAL INFORMATION OR COMMENTS YOU FEEL WOULD BE HELPFUL TO BARABOO RIVER EQUINE-ASSISTED THERAPIES, INC._____

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RIDERS MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant:_____ DOB:_____Must have info to match to a horse.
Height:_____Weight:_____ Body shape: Apple_____ Pear_____ String bean_____
Address:_____
Primary Diagnosis:_____Date of Onset:_____
Secondary Diagnosis:_____Date of Onset:_____
Shunt Present: Y N Date of last revision:_____
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices:_____
For those with Down Syndrome: AtlantoDens Interval X-rays, Date_____Result: + -
Neurologic Symptoms of AtlantoAxial Instability:_____
Please indicate current or past special needs in the following system/areas, including surgeries:

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

Additional Physician Instructions noted on reverse side of this form: _____YES _____NO

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 Baraboo River Equine-Assisted Therapies, Inc., will weigh the medical information given against the existing precautions and determine eligibility for participation.
Name/Title_____MD DO NP PA Other_____
Signature:_____Date_____
Address:_____
Phone:_____License/UPIN Number_____

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

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed).

PHYSICAL FUNCTION: (i.e., mobility skills such as transfers, walking, wheelchair use, driving, bus riding)

PSYCHO/SOCIAL FUNCTION: (i.e., work/school including grade completed, leisure interests, relationship-family structure, support systems, companion animals, fears, concerns, etc)_____

GOALS: (i.e., Why are you applying for participation? What would you like to accomplish?)_____

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/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Neurologic
Hydrocephalus/shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis due to Spinal Cord Injury
Seizure Disorders

Medical/Surgical
Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebro-vascular Accident)

Secondary Concerns
Behavior problems
Age less than two years
Age two-four years
Acute exacerbation of chronic disorder
Indwelling catheter

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LIABILITY, PHOTO, MEDICAL CONSENT RELEASE
NEEDS TO BE COMPLETED FOR ALL RIDERS, VOLUNTEERS and STAFF
PARENT/GUARDIAND SIGNATURE FOR ANY PARTICIPANT UNDER AGE OF 18

LIBILITY RELEASE

I/ my child/ my ward would like to participate in the Baraboo River Equine-Assisted Therapies, Inc. (B.R.E.A.THE.) Program as a rider, volunteer, or staff person. I acknowledge the risk and hazardous nature of horse activities and horseback riding. However, I feel that the possible benefits are greater than the risks assumed. I hereby, intending to be legally bound for myself, my heirs, assigns, executors or administrators, waive and release forever all claims for damages against Baraboo River Equine-Assisted Therapies, Inc., its Board of Directors, instructors, therapists, aides, volunteers, horse owner and/or employees and Wild Rose Ranch LLC, and Dan and Michelle Gillette as stable and property owners for any and all injuries and/or losses that I/ my child/ my ward may sustain while traveling to or from, or participating in any B.R.E.A.THE activities.

Signature:_____ Date:_____

Parent or Guardian:_____Date:_____

Wisconsin State Statutes Sec. 95.481

Notice: A person who is engaged for compensation in the rental of equines or equine equipment or tack in the instruction of a person in the riding or driving of equine or in being a passenger upon an equine is not liable for injury or death of a person involved in equine activities resulting from the inherent risks of equine activities, as defined in Section 895.481 (1) (e) of the Wisconsin State Statutes.

PHOTO RELEASE

I____DO____DO NOT consent to and authorize the use and reproduction by Baraboo River Equine-Assisted Therapies, Inc., of any and all photographs and any other audio/visual material taken of me for promotional material, educational activities, exhibitions or an other use for the benefit of the program.

Signature:_____Date:_____

Parent or Guardian:_____Date:_____

MEDICAL TREATMENT CONSENT PLAN

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or any other use for benefit of the agency.

I authorize Baraboo River Equine-Assisted Therapies, Inc. to:

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

This authorization includes x-ray, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Consent Signature_____Date_____

MEDICAL TREATMENT 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.

____Parent or legal guardian will remain on site at all times during equine assisted activities.

____In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

Non Consent Signature_____Date_____