Serenity Therapeutic Equine Program (STEP)
RIDERS REGISTRATION AND RELEASE FORM

RIDER'S NAME: _____ DOB: _____ DATE: _____

STREET: _____ CITY: _____ ZIP: _____

HOME PHONE: (____) _____ WORK PHONE: (____) _____ EMERGENCY (____)_____

PARENTS OR GUARDIAN _____

ADDRESS/PHONE IF DIFFERENT THAN ABOVE:
_____ PARENTS/GUARDIAN E-MAIL _____

SEX _____ WEIGHT _____ HEIGHT _____ SCHOOL/GROUP HOME _____

PRIMARY DISABILITY: _____ OTHER DISABILITIES _____

HAS STUDENT EVER RIDDEN A HORSE: _____ YES _____ NO

For Office Use Only

Helmet Size _____

MOBILITY: INDEPENDENT AMBULATION _____YES _____ NO
ASSISTED AMBULATION _____ YES _____ NO
WHEELCHAIR _____YES _____ NO
BRACES/ASSISTIVE DEVICES _____

SPECIAL PRECAUTIONS/NEEDS: _____

******FOR PERSONS WITH DOWN SYNDROME:***

_____ NEGATIVE CERVIVAL X-RAY FOR ATLANTOAXIAL INSTABILITY. X-RAY DATE _____
_____ NEGATIVE FOR CLINICAL SYMPTOMS OF ATLANTOAXIAL INSTABILITY.

TETNUS SHOT: Yes ____ No____ Date ____ Seizure Type _____ Controlled _____
Date of Last Seizure _____ Medications _____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

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 the person's abilities/limitations by a licensed/credentialed health professionals in the implementing of an effective equestrian program.

Physician Name (Please print) _____ Date_____ Phone _____

Physicians Signature_____

Address _____ City _____ State _____ Zip _____

RIDER'S AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

In the even of an 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 Serenity Therapeutic Equine Program 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 medical emergency treatment.

Client's Name: _____ Phone: _____

Address: _____

In the event I cannot be reached, contact: _____ Phone:_____

Or contact: _____ Phone: _____

Physician's Name: _____ Preferred Medical Facility _____

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: _____

Address: _____

Consent Signature _____

Client, Parent or 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 Serenity Therapeutic Equine Program. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date: _____ Print Name: _____ Phone: _____

Address: _____

Non-Consent Signature: _____

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