



BARABOO RIVER EQUINE-ASSISTED THERAPIES, INC.



Rider Registration - 2021

Name of Rider _____ Birthdate _____ Height _____ Weight _____

Address _____ Home Phone _____

City, State, Zip _____ Cell Phone _____

E-mail _____

Is Rider a member or veteran of the Armed Forces, Police or Fire Service? Yes No

IF UNDER 18 YEARS OF AGE, COMPLETE THE FOLLOWING:

Name of School _____

Fathers' Name: _____ Mothers' Name _____

Address _____ Address _____

City/State/Zip _____ City/State/Zip _____

Phone _____ Phone _____

Email _____ Email _____

EMERGENCY CONTACT (other than parent or guardian)

Name _____ Phone _____

Relationship _____ Cell _____

Is Rider currently enrolled in:

Physical Therapy Yes No

Occupational Therapy Yes No

Speech Therapy Yes No

Behavioral/Psychological 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 _____

HAS RIDER EVER RIDDEN A HORSE BEFORE? YES NO

IS RIDER 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. _____

**Mailing Address: Baraboo River Equine-Assisted Therapies, Inc. (B.R.E.A.THE.),
P.O. Box 101, Baraboo, WI 53913**



BARABOO RIVER EQUINE-ASSISTED THERAPIES, INC.



RIDERS MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Rider Name: _____ DOB: _____
 Required to match to a horse: **Height:** _____ **Weight:** _____ **Body shape:** Apple ___ Pear ___ Stringbean ___
 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/GUARDIAN SIGNATURE FOR ANY PARTICIPANT UNDER AGE OF 18**

LIABILITY 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 Virginia Rohde as stable and property owner 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 all photographs and any other audio/visual material taken of me for promotional material, educational activities, exhibitions or another 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 always remain on site during equine assisted activities.

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

Non-Consent Signature _____ Date _____

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LESSON FEES AND PAYMENT INFORMATION

The fee for one, 4-week session riding 1x/week is \$150.00.

The fee for one, 4-week session riding 2x/week is \$280.00.

The entire payment is due in advance, and no later than the 1st lesson of the session. Please provide payment and billing information below:

Riding fees will be paid by:

_____ Individual

_____ Organization

If Organization, has payment been preapproved?

_____ Yes _____ No

Party responsible for payment:

Name _____

Address: _____

Relationship: _____

Email: _____

Phone: _____

We accept Visa, M/C, Check, and Cash payments. Credit Card payments incur a 3% processing fee.

Please charge my card:

Card No: _____

Expiration: _____ CCV: _____

Name on Card: _____

Zip Code Associated with this Card: _____

_____ Please keep my card number on file for future charges (signature required)

Signature
