SPECIAL TROOPERS ADAPTIVE RIDING SCHOOL

33148 K22—Sioux City, IA 51108—www.scstars.org—P: 712.239.5042—F: 712.224.3471

Participant Registration Form

Please Print Legibly Date: ________________

Parent/Guardian Name: ________________________________

Address: ____________________ City: ____________ State: ________ Zip: ________

Primary Phone: ____________________ Secondary Phone: ____________________

Email: ____________________ Best way to contact you: ☐ Email ☐ Phone ☐ Text

Client Name: ____________________ Age: ________ DOB: ________________

Address (if different): ____________________ City: __________ State: ______ Zip: ________

School presently attending ____________________ Year in School: ____________________

Diagnosis or Description of Disability: ________________________________

Current Medications: ________________________________

Height: ________________ Weight: ________________ **(Must be filled out to participate)**

Balance Ability: ________________________________

Cognitive Ability: ________________________________

Does client knows Left & Right? Yes ☐ No ☐

Communication Abilities: ________________________________

____

Attention: ________________________________

Disposition/Social/Behavior: ________________________________

Animal Abuse: Yes ☐ No ☐ Other:________________________________

Any changes (Behavioral, medications, health, etc.) Yes: ☐ No ☐ If yes, please explain: ____________

____

____

What are you goals for your client in the coming year? ________________________________

____

____

____

What sessions will they be riding? 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ All Sessions ☐ Notes: ________________

Best Day: 1st choice: M ☐ T ☐ W ☐ TH ☐ 2nd choice: M ☐ T ☐ W ☐ TH ☐

Best Time: 1st choice: 5 ☐ 6 ☐ 7 ☐ 2nd choice: 5 ☐ 6 ☐ 7 ☐ Other: ________________

STARS, Inc. has the right to refuse services to any potential client if he or she exceeds a safe weight limit or poses any other safety concern.

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Participant's Medical History and Clinician's Authorization

STARS, Inc. is a therapeutic riding program designed to benefit the riders physically, socially, and emotionally. In order to assure the fullest possible protection and greatest personal benefit from the program, each rider is required to furnish the following medical information before being accepted as a riding student.

Client:___________________________________ **DOB:** _______________ **Height:** ___________ **Weight:** _________

(Bold must be filled out to participate)

Address:____ City:____________ State: _______ Zip:______________

Diagnosis:____ Date of Onset: ______________________________________

Past/Prospective Surgeries: ____

____

Medications: ____

____

Allergies: ____

Seizure Type: __________________________ Controlled: Y N Date of Last Seizure: ___________________________

Shunt Present: Y N Special Precautions/Needs: ____

Neurologic Symptoms____

Mobility: (Please Circle) Independent Crutches Cane Braces Walker Wheel Chair

Incontinence: ________________________

For those with Down Syndrome: Atlantoaxial X-rays, date: __________ **Instability: Y N**

Please indicate current or past difficulties in the following systems/areas, including surgeries:

Auditory: Y N Comments: ____

Visual: Y N Comments:____

Tactile Sensation: Y N Comments:____

Speech: Y N Comments:____

Cardiac: Y N Comments:____

Circulatory: Y N Comments:____

Integumentary/Skin: Y N Comments:____

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Immunity: Y N Comments:____

Pulmonary: Y N Comments:____

Neurological: Y N Comments:____

Muscular: Y N Comments:____

Balance: Y N Comments:____

Orthopedic: Y N Comments:____

Environmental Allergies: Y N Comments:____

Learning Disability: Y N Comments:____

Cognitive: Y N Comments:____

Emotional/Psychological: Y N Comments:____

Pain: Y N Comments:____

Other: Y N Comments:____

In my opinion, this client can receive therapeutic horseback riding under appropriate supervision. However, I understand that STARS, Inc. will determine whether they can safely provide services.

CLINICIAN NAME (PRINT): ______________________________ **DATE:** ____________________

CLINICIAN SIGNATURE: ______________________________ **STAMP ADDRESS HERE:**

(FORM CAN BE SIGNED BY PHYSICAN, CERTIFIED NURSE PRACTIONER OR PHYSICIAN ASSISTANT)

LICENSE UPN # ______________________________

ADDRESS: ______________________________

CITY/STATE/ZIP: ______________________________

PHONE: ______________________________

(MUST BE FILLED OUT TO PARTICIPATE)

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event 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 STARS, Inc. I authorize STARS, 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 medical emergency treatment.

Client's Name: ____Phone________________________

Address:_______________________________________City:_____________State: ______ Zip:_____________

In the event I cannot be reached:
Contact Name (1): ____Phone: ______________________

Contact Name (2):____ Phone: ______________________

Physician's Name:__________ ____________________________________ Phone: ______________________

Preferred Medical Facility:____

Health Insurance Company:_______________________________________ 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.

Consent Signature: ____Date: _____________________
Client, Parent/Guardian
Print Name: ____Phone: _____________________

Address: ____

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 STARS, Inc. In the event emergency treatment/aid is required, I wish the following procedures to take place:

____

____

Non-Consent Signature: ____Date:_______________________
Client, Parent/Guardian
Print Name: ____ Phone:______________________

Address:_______________________________________City:_____________State: ______ Zip:_____________