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:____________

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STARS POLICY: MEDICAL INFORMATION PRIVACY

We value our relationship with our clients and we take our clients' personal privacy seriously. Privacy has always been important to STARS. We have safeguards in place to protect medical information about our clients. Only STARS instructors have access to medical information to assist them in class instruction. We continually review our policies and practices and monitor our handling of the medical information of our clients to help us ensure your privacy.

STARS instructors collect and use medical information that we believe is necessary to conduct our classes. We require our instructors to protect the confidentiality of our clients. We do not provide or share medical information about our clients to anyone other than STARS instructors, with the exception that STARS instructors be able to disseminate medical information to other individuals, such as volunteers, in order to provide the safest and highest quality lessons for our students.

This handout informs you of STARS policies and practices for collecting, using, and securing the medical information you provide to us.

Only instructors will collect documents containing medical information and they will promptly file the same into a locked file cabinet, which is located inside the office. The instructors will not permit anyone else to view the documents or file folders. Only instructors will have a key to this locked file cabinet. This file cabinet will remain locked at all times and will only be accessed by an instructor for the specific purpose of preparing for lessons. The instructors will destroy documents containing medical information 30 days after a client has permanently left the program. This determination shall be made by the STARS instructors and a reminder letter will be sent out to the parent or guardian requesting them to retrieve the medical documents.

Please sign and date below indicating that you have read this policy and understand it. Thank you for helping STARS. We appreciate the opportunity to serve you.

Client Name: ____

____

Signature of Parent/Guardian (if client is under 18)

____

Print Name of above Signature

Date ____________________

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CLIENT PHOTO RELEASE

I hereby **consent ☐ or do NOT consent ☐** that Special Troopers Adaptive Riding School, Inc. (STARS) has permission to take or have taken, still and moving photos, videotape, digital photographs, films, television images, and images taken or made by any and other manner or method of our/my (self-daughter-son-ward), Client name: ________________________________, and consents and authorizes STARS, its advertising agencies, news media, and any other persons interested in STARS, to use and reproduce the photos, films, pictures and images and circulate and publicize the same by any and all means without limitation; including but not limited to the following: newspapers, television, media, brochures, pamphlets, instructional material, books, web site, and clinical material.

No inducements or promises of any kind have been made to us/me to secure our/my signature(s) to this release other than the intention of STARS to use or cause to be used such photographs, films, pictures or images for the primary purpose of promoting and aiding STARS and its work.

Signature(s)____

____

Dated: _________________________________

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Iowa passed a law effective July 1, 1997, regarding liability of providers of activities involving domesticated animals. Please read the following statements. You are provided two copies, one for our records (that you will need to sign as verification for having received the notice) and one for your own records.

IOWA CODE CHAPTER 673 WARNING

UNDER IOWA LAW, A DOMESTICATED ANIMAL PROFESSIONAL IS NOT LIABLE FOR DAMAGES SUFFERED BY, AN INJURY TO, OR THE DEATH OF A PARTICIPANT RESULTING FROM THE INHERENT RISKS OF DOMESTICATED ANIMAL ACTIVITIES, PURSUANT TO IOWA CODE CHAPTER 673. YOU ARE ASSUMING INHERENT RISKS OF PARTICIPATING IN THIS DOMESTICATED ANIMAL ACTIVITY.

A number of inherent risks are associated with a domesticated animal activity. A domesticated animal may behave in a manner that result in damages to property or an injury or death to a person. Risks associated with the activity may include injuries caused by bucking, biting, stumbling, rearing, trampling, scratching, pecking, falling, or butting.

The domesticated animal may act unpredictably to conditions, including, but not limited to, a sudden movement; loud noise; an unfamiliar environment; or the introduction of unfamiliar persons, animals, or objects.

The domesticated animal may also react in a dangerous manner when a condition or treatment is considered hazardous to the welfare of the animal; a collision occurs with an object or animal; or a participant fails to exercise reasonable care, take adequate precautions, or use adequate control when engaging in a domesticated animal activity, including failing to maintain reasonable control of the animal or failing to act in a manner consistent with the person's abilities.

I have read and understand the above statements. I have also received a copy of the statements for my own records.

____

Volunteer, Rider, Parent, or Guardian

Date: ______________________________

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CLIENT RELEASE FORM

LIABILITY RELEASE AND INDEMNITY AGREEMENT

I,_______________________________________ would like to participate in the Special Troopers Adaptive Riding School (STARS, Inc.) program. I acknowledge the risks and potential for risks of horseback riding, and agree to assume all risks of personal injuries and damages regarding involvement in the program. However, I feel that the possible benefits to myself/ my son/ my daughter/ my ward are greater then the risk assumed. Therefore, in return for being permitted to participate, and intending to be legally bound, for myself, my heirs, and assigns, executors of administrators, I hereby forever waive and release all claims for damages against STARS, Inc., its Board of Directors, Sponsors, Instructors, Therapists, Aides, Volunteers, Employees, Agents or others on its behalf liable for any and all injuries and/or losses I / my son/ my daughter/ my ward may sustain while participating in STARS, Inc., and agree to indemnify them from all loss, expense, damages, and costs they may incur by reason of any claim for damages brought against them. I have read, understand, and agree to all of the terms of this liability release and indemnity agreement.

Signature:_______________________________________ Date:______________________
(Client, Parent, or Guardian)

Witness:____ Date:________________