SPECIAL TROOPERS ADAPTIVE RIDING SCHOOL
33148 K22—Sioux City, IA 51108—www.scstars.org—P: 712.239.5042—F: 712.224.3471

For Office Use:
Date received:
_____

RETURNING PARTICIPANT REGISTRATION

Please print legibly

PARTICIPANT NAME: _____ Age: _____ DOB: _____

Parent/Guardian Name(s): _____

Height: _____ Weight: _____ **(Required to Participate)**

Participant's T-shirt Size: Youth ☐ _____ Adult ☐ _____

Describe any recent updates/changes to medical, behavioral, diagnosis, etc. An updated Physician's form may be required with medical updates. _____

_____

_____

What goals would you like the participant to work on in the coming sessions? _____

_____

_____

Would you like to sign this participant up for the STARS Horse Show in September? (If yes, be sure to add T-Shirt size above.) Yes ☐ No ☐

Please update the following information with any changes.

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____ Best way to contact you: Email ☐ Phone ☐ or Text ☐

Any Additional Information to share? _____

_____

PAYMENT CONTRACT & AGREEMENT

The payment contract and agreement will remain the same. Session fees for a 6-week session of Therapeutic Riding will remain $189 and a 6-week session of Ground Work will remain $94.50. All session fees will be due prior to participation. A $30 deposit is required with registration and will be applied to the Participant's session fees.

***STARS, Inc. reserves the right to refuse or discontinue services at any time for current or potential participants if the participant exceeds a safe weight limit or poses other safety concerns of any nature.**

Signature (Self, Parent, or Guardian): _____ Date: _____

Printed Name: _____ Relationship to Participant: _____

If under 18 years of age, Parent/Guardian MUST sign

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PHYSICIAN'S AUTHORIZATION & PARTICIPANT'S MEDICAL HISTORY

To be completed by Physician. Please fill out completely.

STARS, Inc. is a therapeutic/adaptive horseback riding program designed to benefit the participants 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 prior to riding in the program.

PARTICIPANT NAME: _____ Age: _____ DOB: _____

Parent/Guardian Name(s): _____

Address: _____ City: _____ State: _____ Zip: _____

Diagnosis: _____ Date of onset: _____

Medications: _____

Height: _____ Weight: _____ (Required to Participate.)

Allergies: _____

Seizure Type: _____ Controlled: Yes ☐ No ☐ Date of Last Seizure: _____

Shunt Present: Yes ☐ No ☐ Special Precautions/Needs: _____

Mobility: Independent ☐ Crutches ☐ Cane ☐ Braces ☐ Walker ☐ Wheel Chair ☐

Persons with Down Syndrome - Atlantoaxial Instability: Positive ☐ or Negative ☐ Date of X-Ray: _____

Please indicate problems and/or surgeries in any of the following areas. If yes, please comment.

AREAS	YES	NO	COMMENT
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Learning Disability			
Cognitive			
Psychological			
Other			

It is my opinion, this participant can receive therapeutic/adaptive horseback riding under the appropriate supervision at Special Troopers Adaptive Riding School, (STARS, Inc.) and understand that STARS, Inc. will determine whether they can safely provide services to this participant.

Physician's Signature: _____ Date: _____

Physician's printed name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury while receiving services, being on property, or participating in an authorized activity of STARS, Inc., I authorize Special Troopers Adaptive Riding School (STARS, Inc.) to:

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

PARTICIPANT NAME: _____ Age: _____ DOB: _____

Parent/Guardian Name(s): _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

In the event the Parent/Guardian listed above cannot be reached, contact:

Contact Name: _____ Relationship: _____ Phone: _____

Contact Name: _____ Relationship: _____ Phone: _____

Physician's Name: _____

Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

CRITICAL HEALTH INFORMATION

(Ex: DNR, Food Allergies, Medication Allergies, etc.) ☐ None ☐ Yes - Please note below

_____

_____

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.

Signature (Self, Parent, or Guardian): _____ Date: _____

Printed Name: _____ Relationship to Participant: _____

If under 18 years of age, Parent/Guardian MUST sign

NON-CONSENT

*I do **NOT** give my consent for emergency medical treatment/aid in the case of illness or injury. Please note that by signing the non-consent this may exclude you from participating in programming at STARS Inc.*

Signature (Self, Parent, or Guardian): _____ Date: _____

Printed Name: _____ Relationship to Participant: _____

If under 18 years of age, Parent/Guardian MUST sign