Hoofbeats Therapeutic Riding Center, Inc.

At the Virginia Horse Center
P.O. Box 979, Lexington, VA 24450
Ph: 540 464-3337 e-mail: hoofbeats@rockbridge.net
Website: www.hoof-beats.com

Professional Association of Therapeutic Horsemanship International
A Premier Accredited Member Operating Center

***** Please note that horseback riding is contraindicated for some conditions/individuals, and Hoofbeats reserves the right to consider each application and deny services to individuals based upon concerns for the applicant's safety and/or the safety of the horses, volunteers, staff, or property owners, or for other reasons. Please refer to Hoofbeats' Policies and Barn Rules for guidelines. *****

PARTICIPANT REGISTRATION AND RELEASE FORM

Client Name: _____ Date of Birth: _____ Age:_____

Street/P.O. Box: _____ City _____ State_____ Zip_____

Home Phone: _____Work Phone_____ Cell Phone_____

E-mail:_____

Parents or Guardian(s): _____

Address_____Phone:_____

Adult Caretaker, if any: _____Phone:_____

School or institution presently attending: _____

In case of emergency contact: _____Phone:_____

Or contact: _____ Phone: _____

PHOTO/VIDEO/MEDIA RELEASE

I consent to and authorize the use and reproduction by Hoofbeats Therapeutic Riding Center, Inc. of any and all photographs and any other audiovisual, videotape, or digital media materials taken of me/my child/my ward for promotional printed material, internet website, educational activities, exhibitions or for any other use for the benefit of Hoofbeats Therapeutic Riding Center, Inc., the Therapeutic Riding Association of Virginia (TRAV), or the Professional Association of Therapeutic Horsemanship International (PATH).

Date:_____ Signature of Participant:_____

Print Name of Participant:_____

Parents or guardians with legal custody must sign IF participant is under eighteen (18) years of age or otherwise under a legal disability.

Date_____ Signature of Parent/Guardian_____

Print Name_____

Date_____ Signature of Parent/Guardian_____

Print Name_____

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HOOFBEATS THERAPEUTIC RIDING CENTER, INC. WAIVER AND NOTICE

☐ Student ☐ Volunteer ☐ Staff ☐ Board Member

I choose to participate in equestrian activities with Hoofbeats Therapeutic Riding Center, Inc., located at the Virginia Horse Center in Lexington, Virginia. And in order to do so, I agree to the following waiver of liability:

I recognize that there are risks inherent in participating in any equine activity, including: 1) the propensity of an equine to behave in dangerous ways which may result in injury or death of the participant; 2) the inability to predict an equine's reaction to sound, movements, objects, persons, or animals; and 3) certain hazards such as surface or subsurface conditions.

The undersigned, on behalf of himself/herself (hereinafter himself) and all members of his immediate family and household, and his and their heirs, executors, administrators as assigns, (collectively, the "PARTICIPANT") does hereby forever release and discharge HOOFBEATS THERAPEUTIC RIDING CENTER, INC. and its members thereof, of any and all claims, demands, causes of reaction and liability of any nature, which may arise from or in connection with my participation in equestrian activities at HOOFBEATS THERAPEUTIC RIDING CENTER, INC.

The PARTICIPANT hereby agrees to waive and not to assert or bring action at law or in equity or otherwise any claim, demand, cause of action, or liability against HOOFBEATS THERAPEUTIC RIDING CENTER, INC. or its members.

Signature:_____
(Must be 18 years of age or older, or parent/guardian must sign)

Print name as shown above:_____

Child's name (if applicable):_____

Date:_____

Address:_____
Street State Zip

Phone Number:_____ E-mail:_____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

Check one: ☐ Participant ☐ Volunteer ☐ Staff

Name (of Participant, Volunteer or Staff Member):_____ Date of Birth:_____

Address:_____ Phone:_____

Preferred Medical Facility_____

Physician's Name:_____ Phone:_____

Health Insurance Co.:_____ Policy #_____

Emergency Contacts:

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

Allergies to Medications:_____

Current Medications:_____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, volunteering, or while being on the property of the agency, I hereby authorize **Hoofbeats Therapeutic Riding Center, Inc.** to:

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

CONSENT PLAN (Parents/legal guardians must sign for children under 18 or for wards of the court)
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:_____ Consent Signature:_____

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, volunteering, or while being on the property of the agency. In the event emergency aid/treatment is required, I wish the following procedures to take place (If you choose this plan, you must fill in some specifics for the aid which you will/will not allow)

_____

_____

_____

Date:_____ Non-Consent Signature:_____

Print Name:_____

Phone:_____ Address:_____

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TO OUR RIDER: Please note that this *Medical History Form* requires your physician's input and signature. Make sure you allow your physician adequate time to fill out this form and return it to you, so that you can bring it to Hoofbeats before the start of lessons. HOOFBEATS MUST HAVE IN HAND THIS COMPLETED AND SIGNED MEDICAL HISTORY FORM BEFORE YOU WILL BE ABLE TO RIDE.

PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT
(To be completed annually by Primary Physician)

Participant's Name:_____ Date of Birth:_____

Address:_____

Height:_____ Weight:_____

Name of Parent/Guardian/Adult Caregiver, if any:_____

Diagnosis:_____ Date of onset:_____

**For persons with Down Syndrome: _ Negative Cervical X-ray for Atlantoaxial Instability X-ray Date:_____

_ Negative for clinical symptoms of Atlantoaxial Instability.

Tetanus Shot _ Yes, Date: _____ _ No

Seizure Type_____Controlled_____Date of last seizure_____

Medications:_____

_____

Precautions for outdoor activities? (Allergies, sun/heat sensitivity, asthma, etc.)_____ 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 Disabilities	☐	☐	
Mental Impairment	☐	☐	
Psychological Impairment	☐	☐	
Other	☐	☐	

Mobility: Independent Ambulation ☐Yes ☐No; Crutches ☐Yes ☐ No; Braces ☐Yes ☐No Wheelchair ☐Yes ☐No
Please indicate any special precautions_____

Continued next page

Participant's
Name:_____

PHYSICIAN'S STATEMENT

To my knowledge there is no reason why this person cannot participate in supervised equestrian and outdoor activities. However, I understand that Hoofbeats Therapeutic Riding Center may contact me to discuss this information and will weigh the medical information above against the existing precautions and contraindications. I concur that a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) may be helpful in the implementing of an effective equestrian program.

Physician Name (Please Print)_____

Physician Signature:_____ Date_____

Address_____City_____State_____Zip_____

Phone: _____

Information for Physician

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 (Cerebrovascular Accident)

Secondary Concerns
Behavior Problems
Age under 2 years
Age 2-4 years
Acute exacerbation of chronic disorder
Indwelling catheter

Completeed form may be sent to:
Carol Branscome
Hoofbeats Therapeutic Riding Center
P.O. Box 979
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Participant's Consent for Release of Information

Client/Participant Name:_____

Client/Participant Address:_____

Date of Birth:_____

Please List All Current Primary Care Physicians, Therapists (occupational, physical, speech, or mental health professionals), Special Education Teachers, or other professionals who may have information relevant to the safety, health, training, or goals for this participant in a therapeutic riding program. Use the back of this sheet if necessary for additional information;

Name of Professional	Type of Professional	Address	Phone

I hereby authorize any or all of the above-named professionals to release: medical histories; Physical Therapy, Occupational Therapy and Speech Therapy evaluations, assessments, and program plans; Classroom Individual Education Plans (I.E.P); and psychological/psychiatric histories, diagnoses, and evaluations to: **Hoofbeats Therapeutic Riding Center, Inc.** for the purpose of developing a Therapeutic Riding Program for the client named above.
(Parents/legal guardians must sign for children under 18 or wards of the court. Both parents/guardians must sign below if there is joint or shared custody.)

Date:_____Signature:_____Print Name:_____
(Client, Parent, or Guardian)
Date:_____Signature:_____Print Name:_____
(Client, Parent, or Guardian)

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Request to Release Protected Health Information to Provider

I, (Print rider's full name) _____, do hereby authorize and request that Hoofbeats Therapeutic Riding Center release riding/therapy records to the following provider

(Print provider's name) _____, for the purpose of medical care/therapy.

Patient Information

Address: _____ **Date of Birth:** _____

_____ **Social Security No #:** _____

_____ **Phone #: (_____)** _____

Provider Information

Address: _____ **Phone #: (_____)** _____

_____ **Fax #: (_____)** _____

_____ **Send results by:** ☐ **Fax** ☐ **Mail**

I, the Patient or Patient's Representative, understand that:

- *My records are confidential and may be disclosed only as authorized in this consent or required by law.*
- *I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present any written revocation to Hoofbeats Therapeutic Riding Program. The revocation will not apply to records already released prior to Hoofbeats receiving the revocation.*
- *I understand that my record may include information relating to medical conditions. It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.*
- *I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Hoofbeats Therapeutic Riding Center.*
- *This authorization will automatically expire one year after the date below.*

Signature of patient or patient's representative: _____ **Date:** _____

If requested by Patient's Representative, print Representative's Name: _____

Representative's relationship to patient: _____

Identity confirmed by: ☐ **Photo ID (ex. Valid driver's license)** ☐ **Copy of Power of Attorney Attached (If applicable)**

NOTE: This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. Hoofbeats will not release the requested records until a completed form is received. The rider and/or the rider's representative is responsible for providing correct contact information and Hoofbeats will be held harmless if such contact information is incorrect.

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CONFIRMATION OF INTENT TO PARTICIPATE IN THE HOOFBEATS 2017 LESSON PROGRAM

I intend for myself/my child (name:_____) to participate in the following 8-week lesson sessions this year (please check all that apply):

☐ SPRING: April 25 – June 17

☐ SUMMER: June 27 – August 19

☐ FALL: August 29 – October 21

I have read the Hoofbeats Policies and Barn Rules and agree to the rules.

I have read the information in the 2017 Letter from the Program Director, and the information related to the amount and payment of required fees.

I understand that the Hoofbeats office must have in hand a complete set of the client's required paperwork for 2017 before the client may ride.

I also understand that prior to the start of each 8-week riding session in which a client wishes to participate, Hoofbeats must be in receipt of payment of fees in full. Any exception requires a special arrangement with the Hoofbeats Treasurer Ellen Pennine, in advance of the first lesson in which the client plans to ride.

By signing this form, I agree to the terms set forth above, and I commit to participation in the program's lesson sessions I have checked above.

NAME:_____ DATE:_____