Emerald Hollow Therapeutic Riding Center, Inc.

235 Run Hill Road, Brewster, MA 02631

(508) 896-0064

REGISTRATION FORM

Participant's Name: ____ Date of Birth: ___/___/___ Age: ________

School or Institution Presently Attending: ________________________ Teacher's Name: ____________________

Weight: _______ Height: _______ Disability: ____

Primary Contact Name: ____________________________________ Relation: ____________________

Mailing Address: Street ______________________________ City _______________ State _____ Zip ________

Home Phone: ( ) _______________ Cell Phone: ( ) _______________ Email: ____________________

Photo & Publicity Release

_______ I hereby consent and authorize _______ I do not consent to, nor do I authorize
Emerald Hollow Therapeutic Riding Center, Inc. to use my or my child's photograph or image in its print, online, and video publications; and release Emerald Hollow Therapeutic Riding Center, Inc., its employees and any outside third parties from all liabilities or claims that I might assert in connection with the above-described activities; and waive any right to inspect, approve or receive compensation for any materials or communications, including photographs, videotapes, DVDs, website images or written materials, incorporating photos/images of me or my child.

Date: ____________________

Consent Signature (Client, Parent, or Legal Guardian): ____

Liability Release (Required)

________________________ (name) would like to participate in the Emerald Hollow Therapeutic Riding Center, Inc. Program. I acknowledge the risks and potential for risks of horseback riding and related equine activities, including grievous bodily harm. However, I feel that the possible benefits to myself/my child/my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors, and administrators, waive and release forever all claims for damages against Emerald Hollow Therapeutic Riding Center, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my child/ my ward may sustain while participating in the Program from whatever cause including but not limited to the negligence of these released parties. The undersigned acknowledges that he/she has read this Registration and Release Form in its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.

Date: ____________________

Consent Signature (Client, Parent, or Legal Guardian): ____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Participant's Name: ______________________________ Date of Birth: ___/___/___ Age: ________

Weight: _______ Height: _______ Special Needs: ______________________________

Primary Contact Name: ______________________________ Relation: ______________

Mailing Address: Street ______________________ City ______________ State _____ Zip ________

Home Phone: (   ) ______________ Cell Phone: (   ) ______________ Email: ______________

In the event of an emergency

Preferred medical facility: ______________________________

Emergency Contact 1: ______________________________ Relationship: ______________

Home Ph: ______________ Work Ph: ______________ (ext) ____ Cell Ph: ______________

Emergency Contact 2: ______________________________ Relationship: ______________

Home Ph: ______________ Work Ph: ______________ (ext) ____ Cell Ph: ______________

In the event emergency medical aid/treatment is required due to illness or injury while receiving services, or while on the property of EHTRC, I authorize EMERALD HOLLOW THERAPEUTIC RIDING CENTER, INC. to:

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

Consent and Authorization

This release and authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician or other licensed medical provider. **This consent will only be used if the person(s) listed as emergency contacts cannot be reached.**

Date: ____________________

Consent Signature (Client, Parent, or Legal Guardian): ______________________________

EMERALD HOLLOW THERAPEUTIC RIDING CENTER, INC.

PARTICIPANT QUESTIONNAIRE

It is helpful for the staff at Emerald Hollow Therapeutic Riding Center, Inc. to know what your (or your child's) participation goals and interests are, and to understand your (or your child's) current status prior to developing a program for you (or your child). Please complete the following questions:

Participant's Name: ______________________________ DOB: ____________

Please indicate the program(s) you are interested in: Riding ________ Equine Learning ________

Availability: Day(s): ______________________ Times: ______________________

Diagnosis: ____

Posture: ____

Balance: ____

Movement / Coordination: ____

____

General Attitude & Behavior: ____

Perceptual / Balance Problems: ____

Communication Challenges & Methods (Verbal, Sign, PEC): ______________________________

____

Cognitive Abilities (age level, multi step directions) ______________________________

____

What are your goals for the riding sessions (i.e., riding skills, behavioral changes, physical improvements, paying attention). Please be specific ______________________________

____

Are there any special considerations that EHTRC should be aware of? (i.e., health precautions, medications, etc.) ______________________________

____

Describe any previous horseback riding experience ______________________________

____

Areas of interest, games & activities enjoyed ______________________________

____

Please note that Emerald Hollow Therapeutic Riding Center, Inc. may require additional documentation of medical conditions and a clearance from your health care provider.

Signature: ______________________________ Date: ____________

Participant/Parent/Legal Guardian

Emerald Hollow
Therapeutic Riding Center, Inc.

www.emeraldhollow.org

235 Run Hill Road, Brewster, MA 02631
(508) 896-0064

Date: ______________________

Dear Physician:

Your patient, ______________________________ (participant's name) is interested in participating in supervised equestrian activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability – include neurological symptoms
Coxarthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/
Tethered Cord/Hydromyelia

Other
Age – usually under 4 years
Indwelling Catheters/medical equipment
Medications, i.e., photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (e.g., RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the center at the address/phone indicated below.

Sincerely,

Nancy Sheridan

Nancy Sheridan
Executive Director

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant: ______________________________ DOB: __________ Height: ______ Weight: _____
Address: ______________________________
Diagnosis: ______________________________ Date of Onset: __________
Past/Prospective Surgeries: ______________________________
Medications: ______________________________
Seizure Type: ______________________ Controlled? Y N Date of last seizure: __________
Shunt Present? Y N Date of last revision: ______________________________
Special Precautions, Diets/Needs/Allergies: ______________________________
_______ May participate in all activities _______ May participate except for: ______________
Mobility: Independent Ambulation? Y N Assisted Ambulation? Y N Wheelchair? Y N
Braces/Assistive Devices: ______________________________

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

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

IMPORTANT NOTE TO DOCTOR/MEDICAL FACILITY:
If you prefer to provide the requested information on your own medical form, we will accept that only when the below release section is completed, signed & dated & your form is stapled to our form.
To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a referral of the patient to a licensed/credentialed health professional (e.g., PT, OT, Speech, Psychologist, etc) in the implementations of an effective equestrian program.

**FOR PERSONS WITH DOWN SYNDROME:
Neurologic symptoms of Atlanto Axial Instability: ☐ Present ☐ Not Present

Name/Title: ______________________________ MD DO Other: __________
Signature: ______________________________ Date: __________
Address: ______________________________
Phone: ______________________ License/UPIN Number: __________