# HORSES WITH HEART

P.O. Box 2427, Chino Valley, AZ 86323
Office: (928) 533-9178

**Revised January, 2014**

## RIDER REGISTRATION AND RELEASE FORM

***The HwH Mission: To provide a safe and enjoyable equine experience for people with physical, mental and emotional disabilities and encouraging each rider to develop independent skills at their own level of ability.***

### REGISTRATION -

Date Form Completed: _____

Rider's Name: _____DOB:_____ Age: _____

Home Address: _____ City/State/Zip: _____

Home Telephone: _____Work Phone: _____ Cell: _____

Rider's Email Address: _____

Name and Phone Number of Other Contact (as necessary):_____

Parent(s)/Guardian(s): _____

Parent/Guardian's Email Address: _____

Mailing Address (if different than above): _____City/State/Zip:_____

School/Institution presently attending:_____City:_____

……..

### NON-DISCRIMINATION POLICY -

Horses with Heart is committed to providing all participants (riders, volunteers, board members, contractors and staff) with an environment free from all types of harassment and discrimination based on race, color, religion, national origin, sexual orientation, age, gender, physical, emotional or intellectual disability or veteran status. Horses with Heart prohibits and will not tolerate such harassment or discrimination by anyone affiliated with or those who do business with Horses with Heart.

It is our policy to maintain a positive environment free from all forms of harassment or discrimination and to insist that everyone be treated with dignity, respect and courtesy. The purpose of this policy is not to regulate our participants' personal morality. It is to assure that harassment or discrimination does not occur at our facility. All complaints of harassment or discrimination will be thoroughly, promptly and objectively investigated.

Date: _____ Signature: _____

Client, Parent/Guardian (required if 18 years of age or under)

……

### CONFIDENTIALITY STATEMENT –

Volunteers, riders and families have a right to privacy that gives them control over the dissemination of their medical and/or other sensitive information. Horses with Heart shall preserve that right of confidentiality for all individuals in its program. I, by signing below, acknowledge this policy and will abide by it.

Date: _____ Signature: _____

Client, Parent/Guardian (required if 18 years of age or under)

……..

### PHOTO RELEASE -

I, hereby, consent to and authorize the use and reproduction by Horses with Heart, of any and all photographs and any other audio/visual materials taken of me/my child/my ward for promotional printed material, educational activities, exhibitions or any other use for the benefit of the program.

Date: _____ Signature: _____

Client, Parent/Guardian (required if 18 years of age or under)

# RIDER APPLICATION

Horses with Heart

This information is confidential and will only be used by the Riding Instructor to better assist the client.

Date Form Completed: _____

Rider Name: _____Male_____Female_____

Siblings: (Name(s) and Age(s): _____

Disability (Primary and Secondary) _____

Height: _____ Weight: _____ Medication(s)_____

Seizure: Yes _____ No _____ Date of last Seizure_____ Controlled _____

Ambulation (Wheelchair, canes, etc): _____

Doctor's Name/Address/Phone: _____

_____

Therapist's Name/Address/Phone:_____

_____

***Please provide a copy of any current therapy reports to Horses with HEART, Inc.***

Is your therapist willing to interact with Horses with Heart? Yes _____ No_____

School/Education/Day Program: _____

Physical Limitation(s): _____

Effective Positive Reinforcements: _____

Attention Span: _____ Sitting Posture: _____

Visual: _____ Hearing: _____

Speech: _____ Prosthesis: _____

***Please answer the following questions if applicable*** (use extra sheets, if needed):

1. Have there been any significant changes in the rider's condition within the past 3 to 6 months? _____
2. Please let us know of any changes in health or physical development. _____
3. How did you hear about Horses with Heart?_____
4. Is there anything we should know about the rider? _____
5. What are your expectations of Horses with Heart? _____
6. Please indicate any special billing information._____

Additional comments (as needed):_____

_____

***Horses with Heart (HwH) reserves the right to limit participation in mounted activities when, in the professional opinion of HwH staff, risk to safety or well being of the participant, horse, or HwH facilitation team are identified.***

# HORSES WITH HEART -- AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Horses with Heart 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.

Rider/Volunteer Name: _____

Address:_____ City: _____ Zip Code: _____

Telephone: (_____) _____ Date of Birth:_____

Parent/Guardian/Emergency Contact Person: *(Person who is authorized to give temporary assistance/ care in absence of parent/guardian)*

1. Name: _____Phone: (_____)_____ Relationship_____

2. Name: _____Phone: (_____)_____ Relationship_____

3. Physician's Name: _____Phone: (_____)_____

Preferred Medical Facility: _____ _____

Health Insurance Company:_____ Insurance ID_____

## ALLERGIES, MEDICAL CONDITIONS and MEDICATIONS

(Please list any medical problems, special situations, seizure activity, etc.)

_____

_____

## CONSENT PLAN

This authorization includes X-ray, surgery, hospitalization, medical and any treatment deemed "Life Saving" by the physician. This provision will only be invoked if the person listed below is unable to be reached.

Date:_____ Consent Signature:_____

*(Rider, Volunteer or Parent/Guardian if rider or volunteer is under the age of 18)*

PRINT Contact Name:_____ Phone: (_____)_____

Address: _____

## NON-CONSENT PLAN

I do not give my consent to emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the Agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:_____

Date:_____ Non- Consent Signature:_____

*(Rider, Volunteer or Parent/Guardian if rider or volunteer is under the age of 18)*

PRINT Contact Name:_____ Phone: (_____)_____

Address: _____

**No person can be accepted for riding instruction until this form has been completed by the parent/guardian. If the person is of legal age (18), he/she may complete the form, if he/she is legally competent to do so. Riding instruction will be under strict supervision and although every effort will be made to avoid any accident, NO LIABILITY can be accepted by any of the organizations concerned, including Horses with Heart.**

# HORSES WITH HEART

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## MEDICAL HISTORY/PHYSICIAN RELEASE

Name: _____ DOB :_____ Age: _____

Sex:  M  F  Height: _____ Weight: _____ Pulse: _____ BP: _____

Diagnosis: _____

Cause: _____

Seizure Type (if any): _____ Controlled: _____ Date of last seizure: _____

Medications (Type, Purpose and dose): _____

Tetanus Shot:  Yes  No  Date: _____

***Persons with Down Syndrome: This section must be completed in order to participate. Rider can participate only with a Negative result.***

Cervical X-Ray for Atlantoaxial Instability:  Positive: _____  Negative: _____  X-Ray Date:_____

Please indicate if the client has, or had a history of, the following secondary problems, by checking yes or no. If Yes, please include COMPLETE information pertaining to the problem.

| PROBLEM | Yes | No | IF YES, DESCRIBE |
|---|---|---|---|
| Auditory Impairment | | | |
| Visual Impairment | | | Glasses? |
| Speech Impairment | | | |
| Learning Disability | | | |
| Mental Impairment | | | |
| Psychological Impairment | | | |
| Cardiac | | | |
| Pulmonary/COPD | | | |
| Neurological | | | |
| Muscular | | | |
| Orthopedic (Skeletal) / Scoliosis Degree | | | |
| Balance | | | |
| Allergies (Please Include Medications) | | | |
| Asthma | | | |
| Shunts | | | |
| Postural Hypertension | | | |
| Hemophilia | | | |
| Orthotics | | | |
| Other | | | |

**Mobility:** Independent Ambulation:  Yes  No  **Crutches:**  Yes  No  **Braces:**  Yes  No  **Wheelchair:**  Yes  No

Please indicate any special precautions: _____

In my opinion this patient can participate in supervised equestrian activities. In conjunction with these activities, I concur in the referral of the patient to a physical/occupational therapist or other health care professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program.

Physician's Name (PLEASE PRINT):

_____

Physician's Signature _____ Date: _____

Mailing Address: _____ City/State/ZIP: _____ Phone: _____

**THIS FORM IS VALID FOR A PERIOD OF 2 YEARS FROM THE DATE SIGNED. (EXCEPTION: A YEARLY MEDICAL RELEASE IS REQUIRED FOR RIDERS WHOSE MEDICAL DIAGNOSIS INCLUDES ATLANTOAXIAL INSTABILITY AS A POSSIBLE CONTRAINDICATION.) IT MUST HAVE AN ORIGINAL SIGNATURE. A NEW MEDICAL RELEASE MAY BE REQUESTED AT ANY TIME IF NOTICEABLE CHANGES HAVE BEEN OBSERVED BY HwH STAFF MEMBER AND/OR REPORTED BY PARENT OR GUARDIAN.**

**PLEASE RETURN TO: Horses with Heart, P.O. Box 2427, Chino Valley, AZ 86323  Phone: 928-533-9178**

**RIDER/VOLUNTEER NAME: (Please Print)** _____

**PHONE NUMBER: (AREA CODE)** (_____)_____

# HORSES WITH HEART LIABILITY RELEASE

I understand that horses are unpredictable and even the most docile animal can and may step on, bite, push off balance, stumble, throw, or otherwise injure any person working with or around it. I will exercise safety precautions for my own protection, and I agree to abide by the policies and procedures of Horses with Heart, as such policies may be amended from time to time. I also agree to exercise proper care and conduct at all times while on or near any horse.

Neither Horses with Heart nor any of its officers, instructors, volunteers, participants, employees, agents or owners of the property where Horses with Heart events are conducted shall be held liable for any claims, demands, injuries, or damages, arising out of or in connection with my participation in any Horses with Heart event.

I further acknowledge that I will not hold Horses with Heart, its officers, instructors, volunteers, participants, employees, agents or owners of the property where Horses with Heart events are conducted, liable or responsible for any injury sustained by me while participating in activities at sites where horse therapy classes and related events may be held. I ride and/or participate at my own risk, and agree to take all necessary precautions to prevent any and all accidents. These precautions include, but are not limited to, the wearing of protective headgear.

I hereby release Horses with Heart, its officers, instructors, volunteers, participants, employees, agents as well as the owner of the property, where lessons, horse shows or other Horses with Heart, events occur, from all liability for property damage and personal injury to me, and I assume the risk of injury which I may sustain arising from approaching, handling, or riding a horse in connection with Horses with Heart, activities.

This agreement shall apply to any horse or horses being used or maintained upon the grounds where a Horses with Heart event is being held, or any person or equipment affiliated with said event.

Furthermore, I assume full responsibility and liability for the conduct and safety of any and all persons I bring onto the property where Horses with Heart events are conducted, including minors.

**VOLUNTEERS: I represent that I am physically able to undertake all reasonable volunteers' activities and I participate in such activities at my own risk. INITIALS:**_____
**Jr. Vol. Parent/Guardian** (required if under 18 years of age) **INITIALS:** _____

**RIDERS: I represent that I am physically able to undertake riding activities and equine interaction and I do so at my own risk. INITIALS:** _____
**Rider or Parent /Guardian** (required if under 18 years of age) **INITIALS:** _____

WARNING: Under Arizona law, a sponsor or equine professional is not liable for any injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to A.R. S. s12-553.

I have read and understand all of the above and waive any claim which may arise against Horses with Heart, its officers, instructors, volunteers, participants, employees, agents or owners of the property where Horses with Heart events are conducted.

This agreement is effective upon signing and continues so long as I participate in Horses with Heart events. I agree to pay all costs and attorneys' fees arising from any suit, legal proceedings or threatened proceedings that are or may be brought by me contrary to the terms of this Agreement.

_____ _____

**Signature of Rider or Volunteer** **Signature of Parent/Guardian** (required if 18 years of age or under)

**Date:** _____

***Return to: Horses with Heart, P.O. Box 2427, Chino Valley, AZ 86323 (928) 533-9178***