North American Riding for the Handicapped Association

Participant
Program Registration Form

Name of participant _____

Address _____

Phone contact(s) Home _____ Work _____ Cell _____

Email _____

Parent/Guardian Name and Address (if is aplicable or different from above)

_____

_____

Age _____ Weight _____ Height _____

Disability _____

What are your goals for participating in our Program?

- ☐ Improving self esteem
- ☐ Improving trunk stability, muscular tone, posture, motor skills…
- ☐ Improving emotional, mental, soical, skills and/or attitude
- ☐ Equestrian skills
- ☐ Something else (use space below to describe, please)

_____

_____

How did you learn about our Program?

_____

Please describe your experience with horses: _____

Signature of Participant (even if he is a minor) _____ Date _____

Signature of First Parent _____ Date _____

Signature of Second Parent _____ Date _____

Signature of Agent for Parent(s) or Guardian _____ Date _____

I am authorized by the Parents of _____ to sign this document.

My relationship to the parents is _____

Authorization
for Emergency Medical Treatment Form

Name:	DOB:	Phone:
Address:		
E-mail :	Disability:	
Physician's Name:		
Preferred Medical Facility:		
Health Insurance Company:		
Policy #:		
Allergies to medications:		
Current medications:		

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone _____

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 Golden Dreams Therapeutic Riding Center 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.

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(s) above is unable to be reached.

Date: _____ Consent: _____ Signature: _____

Rider, Parent or Legal Guardian

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 the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

_____

Date: _____ Consent: _____ Signature _____

Rider, Parent or Legal Guardian

Release, Waiver and Indemnity Agreement

It is expressly agreed by Participant and any parent or guardian whose signature appears on this document that this Release, Waiver and Indemnity Agreement shall be governed and construed as being sufficient to satisfy the assumption of risk and waiver requirements necessary to relieve equine activity sponsors and equine professionals from liability under the Virginia Equine Activity Liability Act, and that GOLDEN DREAMS is covered by the provisions of that Act. This Release, Waiver and Indemnity Agreement shall be governed and construed by the laws of the Commonwealth of Virginia, regardless of where any injury or loss shall occur. In the event that any portion of this Release, Waiver and Indemnity Agreement shall be declared unenforceable, such declaration shall not affect the remaining terms of this document, which shall survive intact.
Participant has been advised to wear a properly fastened, ASTM-approved protective helmet and hard-soled, heeled footwear at all times while riding or otherwise coming in contact with horses, and expressly assumes the risk of injury resulting from failure to do so and/or from selecting headgear or footwear which does not adequately protect against injury.

CAUTION: READ BEFORE SIGNING

State of Virginia Equine Liability Form
Rev 2004

NOTICE: Please read this document before signing. Signing this document affirms that you have read it and understand it in its entirety

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The Equine Activity Liability laws of the State of Virginia, VA. Code Ann. § 3.1-796.130, state among its statutory provisions that , “NOTICE: Intrinsic dangers in equine activities, include (i) the propensity of equines to behave in ways that may result in injury, harm, or death to persons on or around them; (ii) the unpredictability of an equine's reaction to such things as sounds, sudden movement, and unfamiliar objects, persons, or other animals; (iii) certain hazards such as surface and subsurface conditions; (iv) collisions with other animals or objects; and (v) the potential of a participant acting in a negligent manner that may contribute to injury to the participant or others, such as failing to maintain control over the equine or not acting within the participant's ability.” No participant nor any participant's parent, guardian, or representative shall have or make any claim against or recover from any equine activity sponsor, equine professional, or any other person for injury, loss, damage, or death of the participant resulting from any of the intrinsic dangers of equine activities

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GOLDEN DREAMS
WAIVER AND INFORMED CONSENT TO PARTICIPATE IN EQUESTRIAN ACTIVITIES

I, the undersigned, having read and understood the content of this document, agree and consent to the provisions contained herein. It is my intention and desire to participate in equestrian-related activities including but not limited to, riding or authorization, check rides, horse-handling, ground crew, mounted games, or being present at equestrian activities as an observer or other activity related, however slight, to equestrian activities at events held by GOLDEN DREAMS.
I hereby acknowledge that I am fully aware of the nature, purpose and risks of the equine activities of GOLDEN DREAMS.
I acknowledge that these activities are potentially dangerous and that I voluntarily accept any of the inherent risks involved. In consideration for my being permitted to take part in these activities, I agree to be bound by the rules of GOLDEN DREAMS and to obey the directions of the instructor and other governing officials of activities. I agree to release, hold harmless, and keep indemnified GOLDEN DREAMS – it's officers, participants, managers, employees, agents, volunteers, successors, heirs, horse and property owner and assigns from any and all costs of defending such claims, including attorneys' fees of all claims, actions, costs, expenses and demands in respect to death, injury, loss or damage to my person or property, howsoever caused, arising out of or in connection with my taking part in these Programs even if the same may have been contributed to or occasioned by the negligence of the said body or any of its agents, servants, or representatives. It is understood and agreed that this agreement is to be binding upon myself, my heirs, executors and assigns under the laws of the State of Virginia related to Equine Activity Liability.

I UNDERSTAND THAT THIS IS A LEGAL DOCUMENT. I HAVE READ AND UNDERSTOOD THIS RELEASE AND I UNDERSTAND ALL ITS TERMS. I EXECUTE IT VOLUNTARILY AND WITH FULL KNOWLEDGE OF ITS MEANING AND SIGNFICANCE. I HEREBY ASSUME ALL OF THE RISKS ASSOCIATED WITH EQUINE RELATED ACTIVITIES.

Print Participant's Name: _____

Participant's Signature _____

Date: _____

Signature of 1st Parent or Guardian* _____

Printed Name _____

Date: _____

Signature of 2nd Parent or Guardian* _____

Printed Name _____

Date: _____

*PARENT OR GUARDIAN MUST SIGN IN ADDITION TO PARTICIPANT UNDER EIGHTEEN YEARS OF AGE

BOTH PARENTS WITH LEGAL CUSTODY OF A MINOR MUST SIGN

GOLDEN DREAMS, INC.

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 Medical/Psychological
Atlantoaxial Instability – include neurological symptoms Allergies
Coxa Arthrosis Animal Abuse
Cranial Deficits Physical/Sexual/Emotional Abuse
Heterotopic Ossification/Myositis Ossificans Blood Pressure Control
Joint subluxation/dislocation Dangerous to self or others
Osteoporosis Exacerbations of medical conditions
Pathologic Fractures Fire Settings
Spinal Fusion/Fixation Heart Conditions
Spinal Instability/Abnormalities Hemophilia
Medical Instability
Neurologic
Migraines
Hydrocephalus/Shunt PVD
Seizure Respiratory Compromise
Spina Bifida/Chiari II malformation/Tethered Cord/ Recent Surgeries
Hydromyelia Substance Abuse
Thought Control Disorders
Other
Weight Control Disorder
Age – usually under 4 years
Indwelling Catheters
Medications, i.e., photosensitivity
Poor Endurance
Skin Breakdown
Allergies

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 me as it is indicated below.

Sincerely,
Sue Bell
Program Director
540-687-5800
sue_bell@goldendreamsriding.com

PARTICIPANT'S MEDICAL HISTORY
&
PHYSICIAN'S STATEMENT

Participant: DOB:
Height: Weight: Diagnosis
Address:
Disability
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:
May participate in all activities ? Y N
May participate except for:
Mobility:
Independent Ambulation? Y N Assisted Ambulation? Y N Wheelchair? Y N
Braces/Assistive Devices:
For those with Down Syndrome: AtlantoDens Interval X-rays, date:
Result: + - Neurologic Symptoms of AtlantoAxial Instability: Y N

This participant is up-to-date on all the following routine childhood immunization :

	Y N	**Date:**
Measles		
Rubella		
Tetanus		
Pertussis		
Polio		
Diphtheria		
Other:		

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

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities.

Expected benefits of equine asisted program:

However, I understand that the medical information above will be taken 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.

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

PHOTO RELEASE

I hereby grant GOLDEN DREAMS permission to interview me and/or to use my likeness in photograph(s) /video in any and all of its publications and in any and all other media, whether now known or hereafter existing.I will make no monetary or other claim against GOLDEN DREAMS or it's staff for the use of the interview and/or the photograph(s)/video.

This is a total release in perpetuity to any right, title or interest.

Name (print full name)_____

Signature_____

Relation to subject (if subject is a minor)_____

Address_____

City, State, Zip code_____

Telephone_____