Seaside 4 Therapeutic Riding, Inc.

PO Box 290 256
Brooklyn, NY 11229

Phone: (347)746-7730
Fax: (718)769-6455

REGISTRATION AND RELEASE FORM

Rider's Name_____Date of Birth:_____/____/____Age _____

Weight:_____Height:_____Disability(s): _____

Parent/Guardian Name:_____E-mail: _____

Street:_____City:_____State:_____Zip: _____

Home Phone: ( )_____Business Phone: ( ) _____

E-mail Address: _____

Business Name:_____Address: _____

Emergency contact person:_____Phone: ( ) _____

School or Agency/Program presently attending:

_____

Teacher's/Program Director's Name: _____

School/Agency E-mail address:_____

PHOTO RELEASE:

_____I hereby consent to and authorize

_____I do not consent to nor do I authorize

the use and reproduction of any and all photographs and other audiovisual materials taken of me by Seaside 4 Therapeutic Riding, Inc. for promotional and/or printed material, educational activities, exhibitions, or for any other use for the benefit of the program. I can also rescind my authorization at any time.

Date:_____Signature: _____

(Rev. Jan. 2017)

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LIABILITY RELEASE (Required):

_____(Name) would like to participate in the Seaside 4 Therapeutic Riding, Inc. program. I acknowledge the risks and potential for risks of horseback riding including grievous bodily harm. However, I feel that the possible benefits to me/ 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 Seaside 4 Therapeutic Riding, Inc. Instructors, Therapists, Aides, Volunteers, and /or Employees for any and all injuries and /or losses I/my child/my ward may sustain while participation in the Program from whatever cause. 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.

Name (Print):_____

Signature: _____Date:_____

Witness Name (Print):_____

Witness Signature: _____Date:_____

TESTING RELEASE (NEW RIDERS ONLY):

I have read the letter to prospective Seaside 4 Therapeutic Riding, Inc. riders, parents, and /or teachers. I understand the importance of pre- and post- testing of new riders. I give permission for _____to be tested by Seaside 4 Therapeutic Riding Inc.

Signature: _____Date:_____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Name: _____DOB:_____Phone:_____

Address:_____City _____

State:_____ Zip: _____

Physician's Name:_____

Preferred Medical Facility:_____

Health Insurance Co.: _____

Policy #: _____

Allergies to Medications:_____

Current Medications:

_____

_____

Current Health Concerns:

_____

_____

_____

In the event of an emergency, contact:

Name: _____Relation:_____Phone:_____

Name: _____Relation:_____Phone:_____

Name: _____Relation:_____Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services from Seaside 4 Therapeutic Riding, Inc., I authorize Seaside 4 Therapeutic Riding, Inc. 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.

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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) listed above cannot be reached.

Date:_____ Consent Signature:_____
(Client, Parent, or Legal Guardian, Sign in Presence of Seaside 4 Therapeutic Riding Staff)

NON-CONSENT PLAN

I *do not* give 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 JAMAICA BAY RIDING ACADEMY In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

_____

Date:_____ Non-Consent Signature:_____
(Client, Parent, or Legal Guardian, Sign in Presence of Seaside 4 Therapeutic Riding Staff)

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PARTICIPANT'S CURRENT MEDICAL CONDITION & HISTORY

Participant:_____DOB:_____Height: _____

Address:_____Weight: _____

Diagnosis:_____Date of Onset: _____

Past/Prospective Surgeries: _____

Medications:_____

Seizure Type:_____Controlled? Y N Date of last seizure: _____

Seizure Medication and Dosage:_____

Shunt Present? Y N Date of last revision: _____

Special Precautions/Needs: _____

_____

Mobility:

Independent Ambulation Y N

Assisted Ambulation Y N

Cane Walker Braces - Please Circle One OR

Describe other Assistive Devices: _____

Wheelchair: Y N

For those with Down Syndrome: AtlantoDens Interval X-rays: Date:_____ Result: + -

Neurologic Symptoms of AtlantoAxial Instability: _____
(Please indicate current or past difficulties in the following systems/areas, including surgeries)

	Y	N	Comments
Auditory (Please give details under "Comments" such as mild, moderate, severe or total loss in left/right/both ears Hearing aids and/or cochlear implants etc.)			
Speech (Please give details under "Comments" such as none, or slurred speech, difficult to understand or unintelligible, uses sign language, and then advise us on how best for us to communicate with your family member)			
Visual (Please give details under "Comments" such as partial or total loss of vision, (blind), in left/right/both eyes. Light perception, visual aids such as eyeglasses etc.)			
Tactile Sensation (Please give details under "Comments" such as where they CAN be touched or NOT at all.)			
Cardiac			
Circulatory			
Skin Conditions			
Pulmonary (Please give details under "Comments" such as: uses an inhaler and/or nebulizer, asthmatic, etc.)			
Neurological			
Emotional/Psychological (Describe any relevant behaviors such as those listed below under "Comments": Throws tantrums, damages property, self-abusive or physically/verbally assaults others, runs or wanders away, resists supervision.)			

	Y	N	Comments
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive (If there is an Intellectual Impairment please describe under "Comments" the level i.e. Mild, Moderate, Severe, Profound.)			
Pain (Please describe under "Comments" what body part, and level of pain.)			
Other (Please describe under "Comments.")			

Current medications:

Please include dosage, frequency, and oral or other means given:

Immunizations:

Which immunizations has the child had? **(CHECK ALL THAT APPLY.)**

___ Hepatitis B
___ Rotavirus
___ Diphtheria / Tetanus / Pertussis
___ Haemophilus influenzae type b4
___ Pneumococcal conjugate5 (Pneumonia)
___ Polio
___ Flu
___ Measles / Mumps / Rubella
___ Varicella9
___ Hepatitis A
___ Meningococcal
___ Human papillomavirus
___ Pneumococcal polysaccharide5

PHYSICIAN'S STATEMENT

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Seaside 4 Therapeutic Riding 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 THERAPIST, PSYCHOLOGIST, ETC.) in the implementation of an effective equestrian program.

Name / Title:_____

MD / DO / Nurse Practitioner / Other: _____

Signature:_____Date:_____

Address:

_____

_____

Phone: _____

License/UPIN Number: _____