HORSES WITH H.E.A.R.T., INC.

(Hands-on Equine Assisted Riding Therapy)
P.O. Box 2427, Chino Valley, AZ 86323
Office: (928) 533-9178

Revised August, 2011

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 his/her 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:______________________________

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NON-DISCRIMINATION POLICY -

Horses with H.E.A.R.T., Inc. 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 H.E.A.R.T., Inc. prohibits and will not tolerate such harassment or discrimination by anyone affiliated with or those who do business with Horses with H.E.A.R.T., Inc.

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)

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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 H.E.A.R.T. 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)

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PHOTO RELEASE -

I, hereby, consent to and authorize the use and reproduction by Horses with H.E.A.R.T., Inc., 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

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

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:____

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Please provide a copy of any current therapy reports to Horses with H.E.A.R.T., Inc.

Is your therapist willing to interact with Horses with H.E.A.R.T., Inc. 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 H.E.A.R.T., Inc.____
4. Is there anything we should know about the rider? ____
5. What are your expectations of Horses with H.E.A.R.T., Inc. ____
6. Please indicate any special billing information.____

Additional comments (as needed):____

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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 H.E.A.R.T -- 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 H.E.A.R.T. 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.)

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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 H.E.A.R.T. Inc.

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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.
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. 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 H.E.A.R.T., P.O. Box 2427, Chino Valley, AZ 86323 Phone: 928-533-9178

RIDER/VOLUNTEER NAME: (Please Print) ___________________________________

PHONE NUMBER: (AREA CODE: ( )______________________________

HORSES WITH H.E.A.R.T. 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 H.E.A.R.T., 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 H.E.A.R.T., nor any of its officers, instructors, volunteers, participants, employees, agents or owners of the property where Horses with H.E.A.R.T. 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 H.E.A.R.T. event.

I further acknowledge that I will not hold Horses with H.E.A.R.T., its officers, instructors, volunteers, participants, employees, agents or owners of the property where Horses with H.E.A.R.T. 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 H.E.A.R.T., its officers, instructors, volunteers, participants, employees, agents as well as the owner of the property, where lessons, horse shows or other Horses with H.E.A.R.T. 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 H.E.A.R.T. activities.

This agreement shall apply to any horse or horses being used or maintained upon the grounds where a Horses with H.E.A.R.T. 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 H.E.A.R.T. events are conducted, including minors.

<u>VOLUNTEERS:</u> 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** _________

<u>RIDERS:</u> 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 H.E.A.R.T., its officers, instructors, volunteers, participants, employees, agents or owners of the property where Horses with H.E.A.R.T. events are conducted.

This agreement is effective upon signing and continues so long as I participate in Horses with H.E.A.R.T. 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: ______________________

All information is confidential and will only be used by the Riding Director and/or Instructor to better assist the client. Return to: Horses with H.E.A.R.T., Inc., P.O. Box 2427, Chino Valley, AZ 86323 (928) 533-9178