**RIDER REGISTRATION AND RELEASE FORMS**

Rider’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_

Previous riding experience: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPONSIBLE PARTY IF OTHER THAN RIDER** (if rider is under 18)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell: \_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to rider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to rider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

Carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cell of policy holder:\_\_\_\_\_\_\_\_\_\_

Preferred emergency facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional information that may be important to know i.e. allergies:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHOTOGRAPY, VIDEO AND WEB PUBLISHING**

Riders may be photographed or recorded, and their names published for non-profit use in various ways including, but not limited to: newsletter articles, community newspaper articles, videos, television broadcasts, lesson pictures, and *Red Tail Acres Equestrian Center* web pages. If you do not want yourself or your child to have his/her name, picture or video taken please make your request in writing and return it to *Red Tail Acres Equestrian Center.*  Please initial \_\_\_\_\_\_\_\_\_\_\_\_

**LIABILITY RELEASE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ would like to participate in the *Red Tail Acres Equestrian Center* riding program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to me/my son/my daughter/my ward are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against *Red Tail Acres Equestrian Center,* Instructors, Therapists, Aids, Volunteers, and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in the *Red Tail Acres Equestrian Center* riding program.

**WARNING:**

Under the Michigan Equine Activity Liability Act, an equine professional is not liable for any injury to or death of a participant in an equine activity resulting from an inherent risk of the equine activity.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT NAME OF RIDER, PARENT OR LEGAL GUARDIAN (if rider is not one’s own guardian or over 18)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF RIDER, PARENT OR LEGAL (if rider is not one’s own guardian or over 18)

**CONSENT FOR EMERGENCY MEDICAL TREATMENT**

In case of medical emergency, the undersigned authorizes *Red Tail Acres Equestrian Center* to provide such medical assistance as they determine to be necessary. If the rider named above is younger than 18 years, the undersigned authorizes *Red Tail Acres Equestrian Center* acting through the adult on its staff who has actual care, control, and possession of the child to consent to medical, dental, and surgical treatment of the child when the undersigned cannot be contacted. The undersigned represents to *Red Tail Acres Equestrian Center* that he or she is the child’s parent and either (i) is not divorced from the other parent, or (ii) is divorced from the other parent, but has been authorized by a written court order to give consent to medical and dental care and surgical treatment of the child. The undersigned will indemnify and hold *Red Tail Acres Equestrian Center* its officers, members, employees and agents harmless if he or she is not empowered by law to give this consent.

The undersigned authorizes any licensed physician and/or medical facility to provide any medical/surgical care and/or hospitalization for the child, including anesthetic, which they determine necessary or advisable, pending receipt of a special consent form from the undersigned.

No person can be accepted for riding instruction until this form has been completed by the parent(s)/guardian. If the person is of legal age (18) he or she may complete this form if he or 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 organization concerned with this instruction, including *Red Tail Acres Equestrian Center* in the event of any accident that may occur.

Parent/guardian signature (if rider is under 18)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of rider (over 18) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH HISTORY AND PHYSICIAN REFERRAL FORM**

PRIMARY DIAGNOSIS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SECONDARY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF ONSET: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF ONSET: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST ALL CURRENT MEDICATEIONS:

Please list all current medications (if more room is needed, use back of this page)

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ taken for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_taken for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_taken for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOBILITY: PLEASE CHECK ALL THAT APPLY:

AMBULATORY\_\_\_\_ CRUTCHES \_\_\_\_ WHEELCHAIR \_\_\_\_ BRACES (PLEASE SPECIFIY) \_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **DOES THE RIDER** | Y/N | **COMMENTS** |
| HAVE A HISTORY OF SEIZURES? |  |  |
| FOLLOW SIMPLE DIRECTIONS? |  |  |
| HAVE SPEECH OR LANGUJAGE DIFFICULTIES? |  |  |
| HAVE COMMUNICATION DIFFICULTIES? |  |  |
| HAVE A FEAR OF ANIMALS/HORSES/DOGS |  |  |
| WALK INDEPENDENTLY? |  |  |
| HAVE LIMITED RANGE OF MOTION? |  |  |
| HAVE DECREASED STRENGTH/ENDURANCE? |  |  |
| HAVE POOR BALANCE: SITTING/STANDING? |  |  |
| HAVE PROBLEMS WITH GROSS MOTOR SKILLS? |  |  |
| HAVE PROBLEMS WITH FINE MOTOR SKILLS? |  |  |
| HAVE ALTERED SENSATION? (SPECIFY) |  |  |
| HAVE HEART/CIRCULATORY PROBLEMS? |  |  |
| HAVE DIGESTION/ELIMINATION PROBLEMS? |  |  |
| HAVE BONE/JOINT PROBLEMS? |  |  |
| HAVE ALLERGIES/BREATHING PROBLEMS? |  |  |
| HAVE EMOTIONAL/BEHAVIORALL PROBLEMS? |  |  |

**RIDERS WITH DOWN SYNDROME, PLEASE NOTE:**

DUE TO THE NATURE OF THE ACTIVITY OF HORSEBACK RIDING, NO INDIVIDUAL WITH DOWN SYNDROME DIAGNOSIS CAN BE ACCEPTED FOR RIDING INSTRUCTION WITHOUT PROOF OF A NEGATIVE DIAGNOSIS X-RAY FOR ATLANTOAXIAL INSTABILITY/DISLOCATION CONDITION.

**IF DIAGNOSIS IS DOWN SYBDROME, THIS FORM MUST BE ACCOMPANIED BY ONE OF THE FOLLOWING:**

1. MICHIGAN SPECIAL OLYMPIC DOWN SYNDROM ATHELETE EVALUATION or
2. A SIGNED, DATED STATEMENT FROM A QUALIFIED PHYSICIAN GIVING THE DATE AND RESULTS OF THE DIAGNOSITIC X-RAY FOR THE ATLANTOAXIAL INSTABILITY/DISLOCATION CONDITION

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**PSYCHOTHERAPY: PLEASE INCLUDE A LIST OF GOALS FOR RIDER**

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
4. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
5. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
6. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
7. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
8. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
9. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
10. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please feel free to add another page to expand on goals for participant.

**THIS SECTION MUST BE COMPLETED BY RIDER’S PHYSICIAN OR THERAPIST (if rider is registering for the therapy riding program)**

IN MY OPINION THE PATIENT NAMED ABOVE CAN RECEIVE RIDING INSTRUCTION UNDER APPROPRIATE SUPPERVISION

PHYSICIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSCIAN’S PRINTED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_