



# Rocky Mountain Riding therapy

P.O. Box 909 Louisville, CO 80027 303-494-1299  
www.RMRidingTherapy.org

## REGISTRATION AND RELEASE FORM

### REGISTRATION

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Parents/Guardians Names: \_\_\_\_\_  
Address/Phone (if different): \_\_\_\_\_

School or Institution presently attending: \_\_\_\_\_

Describe client's *abilities* and *difficulties* in the following areas (include any assistance and/or equipment needed):

**Gross motor/mobility** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Fine motor/ arm and hand skills/ eye-hand skills** (include dressing & eating skills) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Communication** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Cognition/ Thinking skills** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Mental Health/Emotional/ Behavior** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Which daily activities and/or skills are most challenging for you? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Why does client wish to participate in equine assisted activities? What would you like to accomplish? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIABILITY RELEASE**

\_\_\_\_\_ (Client's Name) would like to participate in the Rocky Mountain Riding Therapy Program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk 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 Rocky Mountain Riding Therapy, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating at Rocky Mountain Riding Therapy.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Client, Parent or Guardian

**PHOTO RELEASE**

I hereby \_\_\_\_\_ DO CONSENT  
\_\_\_\_\_ DO NOT CONSENT

to and authorize the use and reproduction by Rocky Mountain Riding Therapy of any and all photographs and any other audio/visual materials taken of me/my son/my daughter/ my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Client, Parent or Guardian

**SCHEDULING**

Client is currently available to ride on the following days at the following times:

M \_\_\_\_\_ T \_\_\_\_\_ W \_\_\_\_\_ Th \_\_\_\_\_ F \_\_\_\_\_ Sa \_\_\_\_\_

Client wishes to participate in (please circle): (please refer to our website or call us for descriptions of different programs or to answer any questions about programs):

Therapeutic Riding (group) or Therapeutic Riding(semi-private or private) or Hippotherapy



**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM**

Participant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Medical Facility: \_\_\_\_\_  
Health Insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_

Allergies to medications: \_\_\_\_\_  
Current medications: \_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ 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 Rocky Mountain Riding Therapy 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 emergency contacts above are unable to be reached.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_  
Client, 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: \_\_\_\_\_ Signature: \_\_\_\_\_  
Client, Parent or Legal Guardian



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## PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

\*\*\*\*Entire form must be filled out, signed and dated by a physician.

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ 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/Needs: \_\_\_\_\_

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: \_\_\_\_\_

### PLEASE INDICATE CURRENT OR PAST DIFFICULTIES IN THE FOLLOWING SYSTEMS/AREAS, INCLUDING SURGERIES:

YES NO

COMMENTS

Auditory/auditory processing

Visual/visual processing

Tactile Sensation

Communication

Heart

Circulatory

Skin

Immunity

Breathing

Digestion & Elimination

Neurologic

Muscular

Balance

Bone Joint

Allergies

Learning Disability

Cognitive

Emotional / Mental Health

Behavioral

Pain

Other

**Please note that the following conditions may suggest precautions/contraindications to therapeutic riding. Therefore, when completing the participant's medical history and physician's statement, please note whether these conditions are present and to what degree.**

**ORTHOPEDIC:**

Coxarthrosis  
Cranial Deficits  
Heterotopic Ossification/Myositis Ossifications  
Joint subluxation/dislocation  
Osteoporosis  
Pathologic Fractures  
Spinal Fusion/Fixation  
Spinal Instability/Abnormalities  
Atlantoaxial Instability – Include neurologic symptoms

**NEUROLOGIC:**

Hydrocephalus/Shunt  
Spina Bifida  
Chiari II malformation  
Tethered Cord  
Hydromyelia  
Seizures  
Traumatic Brain Injury

**OTHER MEDICAL**

Allergies  
Indwelling Catheters  
Poor Endurance  
Skin Breakdown  
Blood Pressure Control  
Medication- i.e. photosensitivity  
Exacerbations of medical conditions  
Hemophilia  
Medical Instability  
Migraines  
PVD  
Respiratory Compromise  
Recent Surgeries  
Weight Control Disorder

**PSYCHOLOGICAL:**

Animal Abuse  
Physical/Sexual/Emotional Abuse  
Fire Setting  
Dangerous to self or others  
Substance Abuse  
Thought Control Disorders

**To my knowledge, based on the above medical information, there is no reason why this person cannot participate in equine assisted activities and/or therapies. I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications.**

**Physician's Name:** \_\_\_\_\_ **MD DO NP PA Other:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_ **License/UPIN Number:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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## INFORMATION FORM

The information from this form will be used as anonymous data for grants, funding proposals and reports. Please be sure to answer each question on the form. Fill in the blank or circle the correct answer. Thank you for your help.

### TO BE COMPLETED BY CLIENT, PARENT OR GUARDIAN

#### Participant Information

Date: \_\_\_\_\_ Age: \_\_\_\_\_ Year of Birth: \_\_\_\_\_ Sex: male female

Ethnic Background: Caucasian Hispanic Latino African American Asian  
Pacific Islander Native American Mixed Race Other

Does participant have a disability? \_\_\_\_\_ Is participant a U.S. Veteran? \_\_\_\_\_

City of Residence: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Household size: 1 person \_\_\_\_\_ 2 people \_\_\_\_\_ 3 people \_\_\_\_\_ 4 people \_\_\_\_\_ 5 or more people \_\_\_\_\_

Single Parent Home? No Yes

#### Parent/Guardian Information

Are parent(s)/guardian(s) employed? (check all that apply)

1st parent	2nd parent
___ No	___ No
___ Yes: profession? _____	___ Yes: profession? _____
___ Full-time student	___ Full-time student

What is annual family income?

___ \$00.00-\$24,999	___ \$75,000-\$99,999
___ \$25,000-\$49,999	___ \$100,000.00 or more
___ \$50,000-\$74,999	

How did you hear about Rocky Mountain Riding Therapy? \_\_\_\_\_

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