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

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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 symptons

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:_____