

**Therapeion Therapeutic Riding Center, Inc.  
RIDER INFORMATION AND RELEASE FORM**

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
Address: \_\_\_\_\_  
City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home phone: (\_\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_\_) \_\_\_\_\_  
Email address: \_\_\_\_\_  
*If under 18 years old, Parent or Guardian:* \_\_\_\_\_  
Address, if different from above: \_\_\_\_\_  
City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home phone: (\_\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_\_) \_\_\_\_\_  
Email address: \_\_\_\_\_  
If you are a student, school name: \_\_\_\_\_  
School phone number: (\_\_\_\_\_) \_\_\_\_\_ Principal s name: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Your supervisor s name: \_\_\_\_\_ Work phone: (\_\_\_\_\_) \_\_\_\_\_  
May we call you at work? Yes          No

**IN CASE OF EMERGENCY**

Contact name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_  
Contact name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

**LIABILITY RELEASE**

**Indiana State Equine Laws states that:** *Under Indiana law, an equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.*

\_\_\_\_\_ (Client s name) would like to participate in the Therapeion Therapeutic Riding 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 to damages against Therapeion Therapeutic Riding Center, Inc, its Board of Directors, Instructors, Therapists, Aides, Volunteers, Employees, Stable Owners, and/or Stable Employees, as well as for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating at Therapeion Therapeutic Riding.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
*Parent, Guardian, or Client (if client is over 18 years of age)*  
Print name: \_\_\_\_\_

**PHOTO RELEASE**

I hereby consent to and authorize the use and reproduction by Therapeion Therapeutic Riding Center of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, media, website or for any other use for the benefit of the program.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
*Parent, Guardian, or Client (if client is over 18 years of age)*

**PHOTO NON-CONSENT SIGNATURE**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
*Parent, Guardian, or Client (if client is over 18 years of age)*

***THIS FORM IS TO BE UPDATED YEARLY***

**Therapeion Therapeutic Riding Center, Inc.  
Authorization for Emergency Medical Treatment**

**Emergency Information**

*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 Therapeion Therapeutic Riding Center to secure medical treatment and/or emergency transportation if needed and to release client records upon request to the authorized individual or agency involved in the medical emergency treatment.*

**Client s name:** \_\_\_\_\_

Emergency Contact Information:

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

Home phone: (\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_

Work phone: (\_\_\_\_) \_\_\_\_\_

Your Doctor Information:

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Hospital: \_\_\_\_\_ City: \_\_\_\_\_

Health Insurance Co: \_\_\_\_\_ Policy #: \_\_\_\_\_

**CONSENT**

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed lifesaving by the physician. This provision will ONLY be invoked if the person listed as the emergency contact is unable to be reached.

Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Parent, Guardian, or Client (if client is over 18 years of age)*

Print name: \_\_\_\_\_

**NON-CONSENT**

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 Therapeion Therapeutic Riding Center. In the event emergency treatment aid is required, I wish the following procedures to take place:

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

Non-Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Parent, Guardian, or Client (if client is over 18 years of age)*

Print name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

***THIS FORM IS TO BE UPDATED ANNUALLY***

**Therapeion Therapeutic Riding Center, Inc.**  
**HEALTH HISTORY/PHYSICIAN RELEASE**  
***ALL PAGES OF THIS FORM MUST BE UPDATED ANNUALLY***

Form Date: \_\_\_\_\_ Client s Date of Birth: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home phone: (\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_  
 Name of Parent or Guardian: \_\_\_\_\_  
 Parent/Guardian s Home phone: (\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_

Medication names and doses: \_\_\_\_\_

Allergies: \_\_\_\_\_

Tetanus Shot Current?      Yes    No  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ (clients over 185 pounds may not be able to ride due to safety factors)

**\*\*\*\*\*FOR PERSONS WITH DOWNS SYNDROME\*\*\*\*\***

Full flexion and extension X-rays for Atlantoaxial Instability (AAI) is required within 5 years prior to entering Therapeion Therapeutic Riding Center s program. Annual physical examination should reveal no symptoms of AAI. Follow up X-rays should be every 10 years after.

***NO INDIVIDUAL MAY RIDE WITH POSITIVE SYMPTOMS OF AAI.***

Cervical X-ray for AAI Negative \_\_\_\_\_ Date \_\_\_\_\_ Doctor s Initials \_\_\_\_\_

**MEDICAL HISTORY**

*Please circle **Yes** or **No** for each of the following conditions. The presence of a condition will need to be further evaluated before it is determined if it is appropriate for the client to receive riding instruction. This is for the client s safety.*

Spinal Fusion	Yes	No	Location and type _____
Spinal Instabilities or Abnormalities	Yes	No	Location and type _____
Spinal Orthoses	Yes	No	Location and type _____
Internal Spinal Stabilization Devices	Yes	No	Location and type _____
Scoliosis	Yes	No	Location and type _____
Kyphosis/Lordosis	Yes	No	Location and type _____
Hip Subluxation/ Dislocation	Yes	No	Describe _____
Osteoporosis	Yes	No	Degree and type _____
Pathologic Fractures	Yes	No	Degree and type _____
Coxas Arthrosis	Yes	No	_____
Pathologic Fractures	Yes	No	Degree and type _____
Pathologic Fractures	Yes	No	Degree and type _____
Coxas Arthrosis	Yes	No	_____

Client Name: \_\_\_\_\_

Arthritis	Yes	No	Location and type _____
Heterotopic			
Ossification	Yes	No	_____
Osteogenesis			
Imperfecta	Yes	No	_____
Cranial Deficits	Yes	No	_____
Hydrocephalus/Shunt	Yes	No	Location and type _____
Cerebral Palsy	Yes	No	Type _____
Spina Bifida	Yes	No	Location and type _____
Tethered Cord	Yes	No	Degree _____
Chiari II Malformation	Yes	No	Degree _____
Hydromyelia	Yes	No	_____
Spinal Cord Injury	Yes	No	Location and degree _____
Paralysis	Yes	No	Location and degree _____
Seizures	Yes	No	Type _____ Last Seizure Date _____
Controlled with meds	Yes	No	Medications _____
Cancer	Yes	No	Location and type _____
Poor Endurance	Yes	No	Degree _____
Diabetes	Yes	No	Type _____
Controlled with meds	Yes	No	Medications _____
Peripheral Vascular			
Disease	Yes	No	Location and type _____
Varicose veins	Yes	No	Location and type _____
Hemophilia	Yes	No	_____
Hypertension	Yes	No	_____
HIV/AIDS	Yes	No	_____
Other Infectious			
Disease	Yes	No	Type _____
Serious Heart			
Condition	Yes	No	Location and type _____
Stroke (CVA)	Yes	No	Location, type, result _____
Aneurysm	Yes	No	Location, result _____
Known embolus	Yes	No	_____
Known thrombus	Yes	No	_____
Fibromyalgia	Yes	No	_____
Surgeries	Yes	No	_____
Date/type			_____
Date/type			_____
Date/type			_____
Date/type			_____
Date/type			_____
Date/type			_____
Date/type			_____
Date/type			_____
Indwelling Catheter	Yes	No	_____
Chronic Pain	Yes	No	Cause and Type _____
Incontinence	Yes	No	_____
Pregnant	Yes	No	Which Trimester _____

Client Name: \_\_\_\_\_

Internal and Pumps

G-tube	Yes	No	Location and type	_____
Pacemaker	Yes	No	Location and type	_____
Colostomy	Yes	No	Location and type	_____
Insulin pump	Yes	No	Location and type	_____
Other	Yes	No	Location and type	_____
Auditory Difficulties	Yes	No		_____
Visual Difficulties	Yes	No		_____
Wear glasses				
or contacts	Yes	No		_____
Behavior Difficulties	Yes	No		_____
Psychological Issues	Yes	No		_____
Emotional Difficulties	Yes	No		_____
Postural Muscle Tone				
Difficulties	Yes	No		_____
Spasticity/Rigidity	Yes	No		_____
Neuro-Sensation				
Sensitivity	Yes	No		_____
Circulation				
Insufficiency	Yes	No		_____
Contractures	Yes	No	Location	_____
Wears Braces	Yes	No	Location and type	_____
Uses Wheelchair	Yes	No		_____
Uses Walker	Yes	No		_____
Uses Cane or				
Crutches	Yes	No		_____
Describe General Health				

Additional Pertinent  
Information \_\_\_\_\_

**To my knowledge there is no reason why this person cannot participate in supervised equine activities. However, I understand that Therapeion Therapeutic Riding Center, a NARHA center, will evaluate the medical information that has been provided in relation to the existing NARHA precautions and contraindications. I concur with a review of this person s abilities and/or limitations by a Licensed/credential health professional (PT, OT, SLP, MSW, Psychologist, Psychiatrist, etc.) in the implementation of an effective equine activity program for this individual.**

Name/Title (please print) \_\_\_\_\_ MD DO NP PA Other

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone number: (\_\_\_\_) \_\_\_\_\_ Date: \_\_\_\_\_

*Please return this form to :*

*Therapeion Therapeutic Riding Center, Inc.*

*11030 South 200 West*

*Brookston, IN 47923*

*(765) 414-8066*

***ALL PAGES OF THIS FORM MUST BE UPDATED ANNUALLY***