1006 130th Street
Aberdeen, SD 57401
605-226-0199
spurs@nrctv.com
www.SPURSAberdeen.org

SPURS
Therapeutic Riding Center

Special People Using Riding Skills

Riders

Rider's Registration and Release Form

Registration

Rider's Name:_____ DOB:_____ Age:_____ Height:_____ Weight:_____

Address:_____

Phone (H):_____ Phone (W):_____ Emergency Phone:_____

Parent / Legal Guardian / Caregiver Name:_____ Phone:_____

Address:_____

School or Institution presently attending:_____

In case of emergency contact:

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

Rider Liability Release

_____ (client's name) would like to participate in the SPURS Therapeutic Riding Center's program. I acknowledge the risks and potential for risks of a horseback riding program. 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 SPURS Therapeutic Riding Center, 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 in SPURS Therapeutic Riding Center.

Signature:_____ Date:_____
(client, parent or legal guardian)

Photo Release

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

Signature:_____ Date:_____
(client, parent or legal guardian)

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Authorization for Emergency Medical Treatment Form

❑ Participant ❑ Staff ❑ Volunteer

Name:_____ DOB:_____ Phone:_____

Address:_____

Physician's Name:_____ Preferred Medical Facility:_____

Health Insurance Company:_____ Policy Number:_____

Known Allergies to Medications:_____

Current Medications:_____

Are there any special health problems that we should be aware of? ❑ Yes ❑ No

Comments:_____

_____

Emergency Contacts

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

Consent Plan

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 SPURS Therapeutic Riding Center to:

1. Secure and retain medical treatment and transportation, if needed.
2. Release client records upon request to authorized individual or agency involved in the medical emergency treatment.

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 person(s) listed above is unable to be reached.

Consent Signature:_____ Date:_____

(Client, parent or legal guardian. Signed in presence of center staff.)

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,

- Parent or legal guardian will remain on site at all times during equine assisted activities.
- In the event emergency aid/treatment is re uired, I wish the following procedures to take place:

_____

_____

Consent Signature:_____ Date:_____

(Client, parent or legal guardian. Signed in presence of center staff.)

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Letter to participant's physician. Please attach the participant's Medical History and Physician's Statement.

Date:_____

Dear Health Care Provider:

Your patient _____ (participant's name) is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete / update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability - include neurological symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification / Myositis Ossificans
Joint Subluxation / Dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion / Fixation
Spinal Joint Instability / Abnormalities

Neurologic

Hydrocephalus / Shunt
Seizure
Spina Bifida / Chiari II Malformation / Tethered Coed / Hydromyelia

Other

Age - under 4 years old
Indwelling Catheters / Medical Equipment
Medications, e.g. Photosensitivity
Poor Endurance
Skin Breakdown

Medical / Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical / Sexual / Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (e.g. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Susbstance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted activities, please feel free to contact the center using the phone number / email / address above.

Sincerely,
SPURS Therapeutic Riding Center

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Rider's Medical History and Physician's Statement Form

to be completed annually

Rider's Name:_____ DOB:_____

Address:_____

Parent / Legal Guardian Name:_____

Diagnosis:_____ Date of Onset:_____

** For persons with Down Syndrome: ❑ Negative cervical x-ray for atlantoaxial instability Date of X-ray:_____

❑ Negative for clinical symptoms of atlantoaxial instability

Tetanus Shot: ❑ Yes ❑ No Date:_____ Height:_____ Weight:_____

Seizure Type:_____ Controlled:_____ Date of last seizure:_____

Medications:_____

Please indicate if patient has a problem and/or surgeries in any of the following ares by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory	❑	❑	
Visual	❑	❑	
Speech	❑	❑	
Cardiac	❑	❑	
Circulatory	❑	❑	
Pulmonary	❑	❑	
Neurological	❑	❑	
Muscular	❑	❑	
Orthopedic	❑	❑	
Allergies	❑	❑	
Learning Disability	❑	❑	
Mental Impairment	❑	❑	
Psychological Impairment	❑	❑	
Other	❑	❑	

Mobility

Independent Ambulation: ❑ Yes ❑ No Crutches: ❑ Yes ❑ No Braces: ❑ Yes ❑ No Wheelchair: ❑ Yes ❑ No

Please indicate any special precautions:_____

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the SPURS Therapeutic Riding Center will weigh the medical information above against the existing precautions and containdications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech Therapist, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician's Name (please print):_____ Physician's SIgnature:_____

Address:_____

Phone:_____ Date:_____