



Therapeutic Riding Center

## Special People Using Riding Skills

# Riders

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

### 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 authorize 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 required, I wish the following procedures to take place:

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

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

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

*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  
Substance 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 areas 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 contraindications. 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: \_\_\_\_\_