1006 130th Street
Aberdeen, SD 57401
605-226-1099
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 required, 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 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:_____

# Waiver of Responsibility and Release for Injuries

By signing this Waiver of Responsibility and Release for Injuries, I am releasing hereby SPURS Therapeutic Riding Center (SPURS) and any of its volunteers or paid employees that are providing services through SPURS of all responsibility for any injuries sustained while engaged in any equine activity or participating in any other activity while on SPURS' property.

1. The risk of injury from equine activities is significant, including the potential for permanent disability and death. Under South Dakota law, an equine activity sponsor is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to SDCL § 42-11-1, South Dakota revised statutes.

2. Additionally, any volunteer of a nonprofit organization is also immune from liability under SDCL §47-23-29.

3. I knowingly and freely assume all such risks, both known and unknown, even if arising from the negligence of the releases, or other, and assume full responsibility for my participation.

4. I willingly agree to comply with stated and customary terms and conditions for participation.

5. I, for myself and on behalf of my or our heirs, assigns, personal representatives and next of kin,

   HEREBY RELEASE, INDEMNIFY AND HOLD HARMLESS SPURS THERAPEUTIC RIDING CENTER, INC., ITS OFFICERS, OFFICIALS, AGENTS, AND/OR EMPLOYEES, OTHER PARTICIPANTS, VOLUNTEERS, SPONSORING AGENCIES, SPONSORS, ADVERTISERS, AND IF APPLICALBE, OWNERS AND LESSORS OF PREMISES ("RELEASEES") WITH RESPECT TO ANY AND ALL INJURY, DISABILITY, DEATH OR LOSS OR DAMGE TO PERSON OR PROPERTY INCIDENT TO MY INVOLVEMENT OR PARTICIPATION IN ACTIVITIES, WHETHER ARISING FROM THE NEGLIGENCE OF THE RELEASEES OR OTHERWISE, TO THE FULLEST EXTENT PERMITTED BY LAW.

I have read this Waiver of Responsibility and Release for Injuries and fully understand its terms and understand that I have given up substantial rights by signing this Waiver of Responsibility and Release for Injuries and I am freely and voluntarily signing this Waiver of Responsibility and Release for Injuries without any inducement.

Signed this _____ day of _____, 20____.

_____ _____

Participant Witness

_____

Print Your Name

_____

Parent or Guardian Signature, if required