

**REGISTRATION AND RELEASE FORM/  
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

Participant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Disability: \_\_\_\_\_

Primary Contact Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ E-Mail: \_\_\_\_\_

**In the event of an emergency**

Preferred medical facility: \_\_\_\_\_

**Emergency Contact**

1: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ (ext) \_\_\_\_\_ Cell Ph: \_\_\_\_\_  
Emergency Contact 2: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ (ext) \_\_\_\_\_ Cell Ph: \_\_\_\_\_

In the event that 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 Victory Junction/Vic's Riders 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 person(s) listed cannot be reached.** In case of non-consent, please request non-consent form.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_  
Client, Parent, or Legal Guardian

**Photo & Publicity Release**

\_\_\_\_\_ I hereby consent and authorize \_\_\_\_\_ I do not consent to, nor do I authorize

- 1), Victory Junction/ Vic's Riders. to use my (my child's) photograph or image in its print, online and video publications;
- 2) Release Victory Junction/Vic's Riders, its employees and any outside third parties from all liabilities or claims that I might assert in connection with the above-described activities and
- 3) waive any right to inspect, approve or receive compensation for any materials or communications, including photographs, videotapes, DVDs, website images or written materials, incorporating photos/images of me(my child).

Date: \_\_\_\_\_ Relation to Participant \_\_\_\_\_

Date: \_\_\_\_\_ Signature (Client, Parent, or Legal Guardian) \_\_\_\_\_

**Liability Release (Required):** \_\_\_\_\_ (Name) would like to participate in the

Victory Junction/ Vic's Riders Program. I acknowledge the risks and potential for risks of horseback riding and related equine activities, including grievous bodily harm. However, I feel that the possible benefits to myself/my child/my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors, and administrators, waive and release forever all claims for damages against Victory Junction Gang Camp its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my child/my ward may sustain while participating in the Program from whatever cause including but not limited to the negligence of these released parties. The undersigned acknowledges that he/she has read this Registration and Release Form in its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.

Date: \_\_\_\_\_ Signature (Client, Parent, or Legal Guardian) \_\_\_\_\_

Date: \_\_\_\_\_

Dear Health care provider:

Your patient, \_\_\_\_\_ (participant's name)

is interested in participating in supervised equestrian 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 therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

<b>Orthopedic</b>	<b>Medical/Psychological</b>
Atlantoaxial Instability – include neurological symptoms	Allergies
Coxarthrosis	Animal Abuse
Cranial Deficits	Physical/Sexual/Emotional Abuse
Heterotopic Ossification/Myositis Ossificans	Blood Pressure Control
Joint subluxation/dislocation	Dangerous to self or others
Osteoporosis	Exacerbations of medical conditions (eg. RA, MS)
Pathologic Fractures	Fire Settings
Spinal Fusion/Fixation	Cardiac Conditions
Spinal Instability/Abnormalities	Hemophilia
Medical Instability	PVD
Weight Control Disorder	Respiratory Compromise
	Recent Surgeries
<b>Neurologic</b>	Substance Abuse
Hydrocephalus/Shunt	Thought Control Disorders
Seizure	
Spina Bifida/Chiari II malformation/Tethered Cord/ Hydromyelia	
<b>Other</b>	
Age – usually under 3 years	
Indwelling Catheters/medical equipment	
Medications, i.e., photosensitivity	
Poor Endurance	
Skin Breakdown	

**PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT**

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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

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, Diets/Needs/Allergies: \_\_\_\_\_

\_\_\_\_\_ May participate in all activities \_\_\_\_\_ May participate except for: \_\_\_\_\_

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: \_\_\_\_\_

***This participant is up-to-date on all the following routine childhood immunization:***

<b>Immunizations</b>	<b>Y</b>	<b>N</b>	<b>Date:</b>	<b>Immunizations</b>	<b>Y</b>	<b>N</b>	<b>Date:</b>
<b>Measles</b>				<b>Hepatitis B</b>			
<b>Rubella</b>				<b>Mumps</b>			
<b>Tetanus</b>				<b>Chicken pox</b>			
<b>Pertussis</b>				<b>Other</b>			
<b>Polio</b>							

Diphtheria							
Pneumococcal conjugate							

Please indicate current or past difficulty in the following systems/areas including surgeries

	Y	N	Comments:
Auditory			
Visual			
Tactile sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

**IMPORTANT NOTE TO DOCTOR/MEDICAL FACILITY:**

**If you prefer to provide the requested information on your own medical form, we will accept that only when the below**

**release section is completed; signed & dated & your form is stapled to our form.**

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a referral of the patient to a licensed/credentialed health professional (e.g., PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name/Title: \_\_\_\_\_ MD DO Other: \_\_\_\_\_

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

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

Phone: \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_

## Rider Form

### Payment Policy

Lessons will be \$25.00 for a group lesson or \$40.00 for a private lesson with a minimum of a 4-week commitment. There will also be a one-time \$15.00 rider evaluation fee for first time riders in our program. Payment is due the 1<sup>st</sup> of every month if payments are made after the 10<sup>th</sup> of the month there will be an added \$10.00 late fee. If lessons are canceled less than 2 hours before the scheduled time riders will not be able to make up this lesson.

### Lesson Policy

If you know you are going to be missing a lesson, please inform the instructor so a makeup lesson time can be scheduled. Make up lessons **Will Not** be offered to rider that canceled less than 2 hours to their scheduled lesson time.

### Riding Clothes

All rider should dress appropriately: shoes with a heel, riding pants or jeans no shorts so riders do not get saddle rubs, and no baggy pants. An approved safety helmet will be provided for riders but they may supply and use their own helmet after being checked by staff.