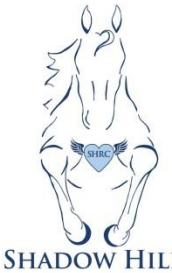


SHADOW HILLS RIDING CLUB RIDER PACKAGE CHECK LIST

10263 La Canada Way Shadow Hills, CA. 90140

All of the forms listed below are required to be completed, checked, signed and dated as indicated prior to the start of rider participation and annually thereafter.

To be completed by rider, parent or caregiver by

- ☐ 1. Rider package check list
- ☐ 2. Rider registration form
- ☐ 3. Contact and tuition payment
- ☐ 4. Rider Release
  - a) Liability release
  - b) Confidentiality agreement
  - c) Photo and video release
- ☐ 5. Authorization for emergency medical treatment form
- ☐ 6. Annual Health History and Contact Information Update Form
- ☐ 7. Possible reasons for discharge form
- ☐ 8. Rider goal sheet

To be completed by the riders physician

- ☐ 9. Information for Physician
- ☐ 10.Rider health history/physician assessment form
- ☐ 11. Cervical X-ray results for Atlanto-axial Instability for persons with Down Syndrome (if applicable) & Physician Release

Client or Parent/Guardian must attach a copy of a valid Drivers License

For office use only

Forms	1	2	3	4	5	6	7	8	9	10	11	12	13	14

SHADOW HILLS
RIDING CLUB

RIDER REGISTRATION

Program Information Date_____

Participant Name: _____ Phone: _____

DOB_____Age_____Height_____Weight_____ Gender M F

Primary Diagnosis_____

Secondary Diagnosis_____

Mobility status (walks unassisted, assistant devices, etc) _____

Address_____

Communication (verbal, non-verbal signs) _____

Behaviors (impulsive, fearful, frustration tolerance) _____

Medications Taken_____

Seizures (if applicable please describe) _____

Limitations_____

Allergies_____

Skin sensitivity_____

Participant's occupation/ school grade level_____

Affiliate Program if applicable_____

Personal Goals (fill in the areas that apply) _____

Physical_____

Cognitive_____

Social/Behavioral_____

Life skills_____

Other_____

Availability for the Shadow Hills Program (Check all available times and days)

Tuesday am_____ Tuesday afternoon_____ Thursday am_____

Thursday afternoon_____ Saturday am_____ Saturday afternoon_____

Start Date_____ (Decided at the assessment)

SHADOW HILLS
RIDING CLUB

Client Contact and Tuition Information

Participant Name: _____

Address_____

City/State/Zip_____

Home Phone _____Cell_____

Email Address_____

Names of parents/guardian:

Father_____Cell_____Email_____

Mother_____Cell_____Email_____

Best Emergency Contact:

Name_____Phone_____Cell_____

Parent occupation and employer:

Father_____ Work Phone_____

Mother_____ Work Phone_____

How were you referred to Shadow Hills Riding Club?_____

2013 Program Tuition Payment Details

Please tell us how you will be paying:

○ Check (please make payable to Shadow Hills Riding Club)

○ Credit Card

I _____ authorize Shadow Hills Riding Club to charge $_____ to my credit card. Date_____

Name on Card_____ Cardholder signature_____

Billing zip code_____ Card Number_____ Exp._____

○ Other:_____

I understand and agree that all paperwork must be up to date and that all tuition is to be paid prior to the start of each session.

Signature of Rider or Legal Guardian_____ Date_____

SHADOW HILLS
RIDING CLUB

Rider Liability Release, Confidentiality Agreement, Photo & Video Release

Participant Name: _____ Date: _____

Parent/Legal Guardian/ Conservator (if applicable) _____

Liability Release:

Name of Parent/Guardian/Conservator_____

I acknowledge the risks and potential risks for horseback riding and activities in and around a facility where horses are kept and farm machinery operated. However, I feel that the possible benefits to me/my son/my daughter/my ward are greater than the risk assumed. Intending legally to bind myself, my heirs, and assigns, executors or administrators, I hereby waive and release forever all claims for loss or damages of any kind against Shadow Hills Equestrian Center and the non-profit program Shadow Hills Riding Club, its' Board of Directors, Instructors, Therapists, aids, Volunteers and employees for any and all injuries and losses that I/my son/my daughter/my ward may sustain while participating in the Shadow Hills Riding Club program. This release includes without limitation the risk of negligent instruction and supervision. I engage in activities at the Shadow Hills Equestrian Center voluntarily with knowledge of the risks and I assume all risks of injury, death, and property damage that may result. I agree to bear any loss myself. I acknowledge that Shadow Hills Equestrian Center and the non-profit program Shadow Hills Riding Club and the property owners are materially relying on this waiver and assumption of risk in allowing me/my son/my daughter/my ward to participate in the Shadow Hills Riding Club activities on the property of Shadow Hills Equestrian Center.

Date_____ Signature_____
(Participant, Parent or Caregiver)

Confidentiality Agreement:

I understand that all the information (written and verbal) about participants at this Professional Association of Therapeutic Horsemanship (PATH, International center) is confidential and not to be shared with anyone without expressed written consent of the participant and their parent/guardian in the case of a minor.

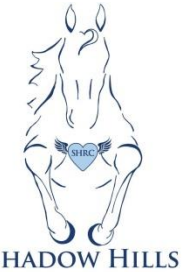
Date_____ Signature_____
(Participant, Parent or Caregiver)

Photo and Video Release:

_____ I consent to and authorize
_____ I do not consent to nor do I authorize

The use and reproduction by Shadow Hills Riding Club of any other audio/visual materials taken of me/my son/my daughter/my ward for distribution to the public for promotional printed materials, educational activities or for any other use for the benefit of the program.

Date_____ Signature_____
(Participant, Parent or Caregiver)



SHADOW HILLS
RIDING CLUB

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

Name_____ DOB_____ Phone_____

Address_____

Physician's Name_____ Preferred Medical Facility_____

Health Insurance Company_____ Policy #_____

Allergies to Medications_____

Current Medications_____

In the Event of an Emergency Contact:

Name_____ Relation_____ Phone_____

Name_____ Relation_____ Phone_____

Consent for Emergency Medical Treatment:

In the event of an 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 _____ to:
(Center's Name)

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.

This authorization includes x-rays surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date_____ Consent Signature_____
Client, Parent or Legal Guardian

Non-Consent for Emergency Medical Treatment:

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 activity
In the event emergency treatment/aid is required, I wish the following procedure to take place

_____

_____

Date_____ Non-Consent Signature_____
Client, Parent or Legal Guardian
Signed in Presence of center staff

Please fill in either the consent or non-consent and sign and date underneath your choice.

Annual Health History and Contact Information Update Form

Date:_____ Name of Participant:_____

Name of Parents/Guardian (if applicable)_____

Address:_____ City:_____ Zip:_____

Home Phone:_____ Cell:_____

Email: (Please print clearly)_____

Participant DOB:_____ Sex:_____ Height:_____ Weight:_____

Diagnosis + changes:_____

Emergency Contact Name:_____

Phone:_____ Relationship:_____

Preferred Medical Facility:_____ Physicians Name:_____

Health Insurance Company:_____ Policy#:_____

Current Medications:_____

Allergies:_____

Precautions/Restrictions:_____

Please explain any recent changes in health or behavior status:_____

_____

_____

_____

_____

_____

Signature:_____ Date:_____

Print Name and Relationship:_____

Possible Reasons for Client Discharge

Please be advised of the following reasons that may lead to discharge from the riding program.

1. The client has reached all of their goals and is ready to graduate.
2. The client's potential to maintain head and neck control while riding presents a safety concern.
3. Inability to follow directions is interfering with progress toward goals.
4. Uncontrolled and/or inappropriate behavior that constitutes a safety risk to client, staff and/or horse.
5. Client exceeds weight that can safely be managed by staff, volunteers, and/or horses.
6. Any change in the client's medical, physical, cognitive, or emotional condition that makes therapeutic riding inappropriate.
7. Three scheduled appointments are missed without prior cancellation.
8. Non-payment of fees as originally agreed.

I understand and agree with the possible reasons for client discharge.

Signature of Client or Legal Guardian:_____

Date:_____

SHADOW HILLS
RIDING CLUB

SHADOW HILLS RIDER GOALS

Please help us help you get the most out of your classes by filling out the following goal setting sheet. Please hand back to your instructor at the next class. Thank you.

Rider name: _____
Parent name: _____
Email address: _____
Class day/time: _____

All goals are reflective of the next term. The categories are meant as a guideline and may not apply to all students.

Riding goals: _____
_____
_____
_____

Physical goals: _____
_____
_____
_____

Cognitive goals: _____
_____
_____
_____

Social goals: _____
_____
_____
_____

Goals Dated: _____

Information for Physician

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Please complete the Shadow Hills Medical Release and Health History Assessment forms. Also, please note if any of the following conditions are present, and to what degree.

Orthopedic

Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathological Fractures
Coxas Arthrosis
Heterotopic Ossification
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Medical/Surgical

Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident)

Neurologic

Hydrocephalus/shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis due to Spinal Cord Injury
Seizure Disorders

Secondary Concerns

Behavior Problems
Age under Two Years
Age Two - Four Years
Indwelling Catheter
Acute Exacerbation of Chronic Disorder

(Please give to the rider's physician as a guideline for Therapeutic Riding)

SHADOW HILLS
RIDING CLUB

RIDER HEALTH HISTORY/ PHYSICIAN ASSESSMENT

Rider Name_____ DOB_____ Height_____Weight_____

Address_____

Diagnosis: _____ Date of Onset_____

Past/Prospective Surgeries: _____

Medications_____

Seizures Y N Type_____ Controlled Y N Date of Last Seizure_____

Shunts/Implants/Appliances _____

Hospitalizations/Surgery_____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Neurologic Symptoms of Atlanto Axial Instability_____

* *Please indicate and comment on any Special Problem Areas Below:*

Area	**Yes**	**No**	**Comments**
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological/Sensation			
Bowel/Bladder			
Muscular			
Orthopedic			
Allergies			
Behavior			
Cognition			
Emotional/Psychological			
Other			

SHADOW HILLS
RIDING CLUB

PHYSICIAN RELEASE

Rider Name:_____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However I understand that Shadow Hills Riding Club will weigh the medical information contained in the physician release form against 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, Therapist, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician's Signature:_____ Date:_____

Physician's name, address and telephone number. (please print, type or stamp):

_____

_____

_____

Down Syndrome Students must have the following: Atlantoaxial Interval X-Ray

Date:_____

Result:_____

(*To be filled out, dated and signed by the Riders Physician and returned to the Program Director for Shadow Hills Riding Club prior to any participation in the program)*

Shadow Hills Riding Club
10263 La Canada Way ~ Shadow Hills, CA. 91040
Office: 818-352-2166
www.shadowhillsridingclub.org
Johnny@shadowhillsridingclub.org