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**

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<th>Forms</th>
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RIDER REGISTRATION

Program Information

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)
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 ____________
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)
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 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)
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:

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**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