The CENTER for Therapeutic and Educational Riding, inc.
A 501 (c)(3) Nonprofit Organization
3491 Harris Road Townsend, DE 19734 • 302-376-9594

Rider Information Sheet

Name of Rider | Today's Date

Current Street Address | City, State, Zip

Home Phone | Cell/Other Phone

Parent/Legal Guardian | Best Contact Number

Doctor's Name | Phone

Person & Relation to Rider to Contact Incase of Emergency & Parent Cannot be reached

Primary Disability | Date of Onset

School/Employer of Rider

Please Check ALL Days & Times that Rider would be available to ride

Monday	☐ AM	☐ PM
Tuesday	☐ AM	☐ PM
Wednesday	☐ AM	☐ PM
Thursday	☐ AM	☐ PM
Friday	☐ AM	☐ PM
Saturday	Reserved for Make-Up Lessons only Scheduled by instructor	

Rider's Interests & Hobbies:

Have they ever ridden a horse before? If so where?

How did you hear about us?

Any other information that may assist us in making this a great experience?

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General Information

Participant's Name

DOB Age Height Weight Gender

Address

Phone E-Mail Alternative Number

Employer/School

Address Phone

Parent/Legal Guardian/Caregiver

Address (if different from above) Phone Number

Referral Source & Phone

How did you hear about the program?

Health History

Diagnosis Date of Onset

Below Please Indicate Current or Past Special Needs in the following Areas:

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

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Medications (please include prescriptions, over the counter, name, dose & frequency)

Describe your abilities/difficulties in the following areas (include assistance/equipment required)

Psycho/Social Function (ie: work/school including grade completed, leisure interests, relationship/family structure, support systems, companion animals, fears/concerns, etc)

Goals (ie: why you are applying for participation? What would you like to accomplish?)

PHOTO RELEASE

I ☐ DO ☐ DO NOT consent to and authorize the use and reproduction by _____ of any and all photographs and any audio/visual materials taken of me for promotional material, educational activities, exhibitions or any other use for the benefit of the program.

Signature of Client/Parent/Legal Guardian Date
(Please sign in presence of center staff)

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Authorization for Emergency Medical Treatment Form

☐ Participant ☐ Staff ☐ Volunteer

Name	DOB	Phone
Address	City, State, Zip	
Physician's Name		Preferred Medical Facility
Health Insurance Company	Policy Number	
Allergies to Medications		
Current Medications		

In the event of an emergency contact:

Name	Relation	Phone
Name	Relation	Phone
Name	Relation	Phone

BELOW PLEASE SIGN ONE OF THE FOLLOWING CHOICES

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 _____(center's name) 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.

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

Consent signature of Parent/Legal Guardian Date
(Signed in presence of center staff)

NON_CONSENT PLAN

I DO NOT give my consent for emergency medial 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 treatment/aid is required, I wish the following procedures to take place:

NON-CONSET Signature of Parent/Legal Guardian Date
(Signed in presence of center staff)

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Letter to Physician

Today's Date: _____

Dear Health Care Provider:

Your Patient, _____ 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
Coxa Arthrosis
Cranial Deficits
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 Cord/Hydromyelia

Other
Age- under 4 years
Indwelling Catheters/Medical Equipment
Medications- ie: 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 (ie: RA, MS)
Fire Setting
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

Thank you very much for you assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities please feel free to contact the center at the above listed address and phone number.

Thank you,
The CENTER

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Participants Medical History & Physician's Statement
(To be completed by Physician)

Participant DOB Height Weight

Address City, State, Zip

Diagnosis Date of Onset

Past/Prospective Surgeries

Medications

Seizure Type Controlled (yes or no) Date of Last Seizure

Shunt Present (yes or no) Date of last revision

Special Precautions/Needs:

Mobility (circle which applies) Independent Ambulation Assisted Ambulation Wheel Chair
Braces/Assistive Devices Used: _____
For those with Down Syndrome: Atlanto Dens Interval X-Rays, date: _____ Result: + -

Neurologic Symptoms of Atlanto Axial Instability
Below, please indicate current or past special needs in the following systems/areas, including surgeries:

	Yes	*No*	*Comments*
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

This must be completed& signed in order for clearance to participate
Given the above diagnosis & Medical information, this person is not medically precluded from participations in equine assisted activates. I understand that the NARHA center will weigh the medical information given against the existing precautions and determine eligibility for participation.

Name/Title:_____ MD DO NP PA Other:_____

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Signature:_____ ***Date:*** _____ ***License/UPIN NUMBER*** _____

Address:_____ ***Phone:***_____

In Consideration of the acceptance of my child, children or self for participating in riding instruction and/or therapeutic riding, the undersigned parent/guardian/self aggress to hold *The Center for Therapeutic and Educational Riding, Inc*., its employees, agents and assistants harmless from any claim for damages arising out of any injury sustained by said child, children or self. ***This must be completed & signed in order for clearance to participate***

_____

Name of Rider Date of Birth

_____

Signature of Parent/Legal Guardian/Self Date

_____

Printed Name of Parent/Legal Guardian/Self

_____

Home Address

_____

Emergency Contact & Phone Number

"Warning- under the Delaware Law, an equine professional is not liable for an injury or the death of a participant in equine activities resulting from the inherent risks of equine activities pursuant to Delaware Code, Title 10, Section 8140."

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