

Client ID # _____



Program Category:

- Camp Onyahsa _____
- Girl Scouts _____
- Therapeutic Horse
Back Riding _____
- Friends and Family _____
- Other _____

Registration and Release Form

Registration

Client: _____ Date of Birth: _____ Age: _____ Sex: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Parent or Guardian: _____

E-Mail: _____

Address/Phone: _____

School or Institution Currently Attending: _____

In Case of Emergency Contact: _____ Phone: _____

Ethnicity:

() Caucasian/White () African-American () Hispanic () Asian/Pacific Islander

() American Indian () Middle Eastern

Liability Release

_____ (Client's name) would like to participate in the Centaur Stride program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/son/daughter/ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs, and my assigns, executors or administrators, waive and release forever all claims to damages against Centaur Stride, its board of directors, instructors, therapeutic 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 Centaur Stride.

Signature (Participant if over 18): _____ Date _____

Signature (parent or guardian): _____ Date _____

Photo Release

I authorize Centaur Stride, Inc. to utilize photographs of me or my minor child. I understand that these images will not be altered and may be used in publications, facility advertisements, or for educational purposes.

Signature _____ Date _____

Authorization for Emergency Medical Treatment

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 _____ 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.

Client Name: _____ Phone: _____

Address: _____

In the event I cannot be reached, contact _____ at _____

Physician Name: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Company: _____

Policy # _____

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 listed below is unable to be reached.

Date: _____

Consent Signature: _____

Print Name: _____ Phone: _____

Address: _____

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. In the event emergency treatment/aid is required. I wish the following procedures to take place:

Date: _____

Non-Consent Signature: _____

Print Name: _____ Phone: _____

Address: _____

Consent for Release of Information

I hereby authorize _____ to release information from the records of _____.

The information is to be released to Centaur Stride for the purposes of developing a Therapeutic Riding Program for the above-named student. The information is to be released as marked below.

- () Medical History
- () Physical Therapy Evaluation, Assessment or Program Plan
- () Occupational Therapy Evaluation, Assessment or Program Plan
- () Speech Therapy Evaluation, Assessment or Program Plan
- () Classroom Individual Education Plan
- () Other:

Date: _____ Signature: _____

(Client, Parent or Guardian)

Medical History/Physician Release

Please complete this form as thoroughly as possible. For items that are not applicable, please write N/A. * For those with physical impairments, a physician must sign this form stating that is OK to participate.

Diagnosis: _____ Date of Onset: _____

Other Information: _____

Seizure Type: _____ Controlled: _____ Date of Last Seizure: _____

Tetanus Shot: Yes: _____ No: _____ Date: _____ Height: _____ Weight: _____

Medications: _____

Allergies: _____

****For Persons with Down Syndrome****

Cervical X-ray for Atlantoaxial Instability: Positive: _____ Negative: _____ X-ray

Please indicate if client has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments/Date of Surgery
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other:			

Mobility: () Independent Ambulation () Crutches () Braces () Wheelchair

Please Indicate Any Special Precautions or Restrictions:

I verify that the information disclosed above is thorough and accurate.

Name _____ Relationship to Rider _____

Signature _____ Date _____

*In my professional opinion this patient can participate in supervised equestrian activities.

Physician Signature Date