Bright Horizons Therapeutic Riding Center
P.O. Box 565
Siletz, OR 97380
(541)961-4156
www.brighthorizonsriding.org

RIDER INFORMATION

Name of Participant_____E-mail_____

Parents/Guardian and/or Caregiver (if applicable)_____

Address _____City_____Zip_____

Home Phone_____Cell Phone_____Other_____

Emergency Contact_____Phone_____

Participant Occupation/School and Level_____

Participant DOB_____Sex_____Height_____Weight_____

Diagnosis_____Date of Onset_____

Parent Occupation and Employer

Father_____Phone_____

Mother_____Phone_____

Past Health History_____
_____

Recent Changes in Health History_____
_____
_____

Medications (Current)_____
_____

Precautions/Restrictions_____
_____
_____

_____ _____
Signature of Participant, or Parent/ Guardian Date

_____
Printed name of above signature/ Relationship to Participant

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Print Participant Name _____
Date of Birth_____
Print Parent/Guardian/Caregiver Name (If Applicable)_____
Address _____
City _____ State _____ Zip__ _____
Home Phone _____ Work Phone__ _____
In The Event I Cannot Be Reached:
Contact _____ Phone _____
Alternate Contact ____ _____ Phone _____
Physician's Name ____ _____ Phone _____
Preferred Medical Facility _____ _____ Phone _____
Health Insurance Co. _ _____ Phone _____
List all pertinent medical information (allergies to food or drugs, medications being taken, special medical conditions:_____
_____
_____

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 the **Bright Horizons Therapeutic Riding Center** 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 invoked if the person listed is unable to be reached.

DATE _____

SIGNATURE of Participant, or Parent/ Guardian of Participant: _____

Print Name_____

Relationship to Participant _____

RELEASE AND HOLD HARMLESS AGREEMENT

The program at the **BRIGHT HORIZONS THERAPEUTIC RIDING CENTER** located at Walker Farms 1925 Logsden, Oregon 97357; provides therapeutic horseback riding for children and adults with special needs and disabilities. Volunteers and horses are carefully selected and trained and safety equipment is required for all riders since horseback riding is a risk exercise.

No student will be accepted to participate in the program, and no volunteer accepted for service until this form has been **READ, UNDERSTOOD, COMPLETED AND SIGNED** by the parent(s), caregiver(s) and/or guardian(s) of a minor, or if the student or volunteer is of legal age and sound mind, by the student or volunteer.

Although participation in the program is under strict supervision and every effort is made to avoid injury or accident, the undersigned acknowledges the inherent risks involved in riding and working around horses. This includes bodily injury from horseback riding or being in close proximity to horses. Among other risks, both horse and rider can be injured in normal use or in competition and schooling. In order to provide this valuable service, **NO LIABILITY** can be accepted by the **BRIGHT HORIZONS THERAPEUTIC RIDING CENTER located at Walker Farms 1925 Logsden,Oregon 97357, Walker Farms** or any of the organizations or persons connected with the above named facility.

IN CONSIDERATION, for the privilege of riding and/or working around horses at the **BRIGHT HORIZONS THERAPEUTIC RIDING CENTER,** the undersigned, as self, or as parent(s) or guardian(s) of the undersigned minor, jointly and severally, do hereby agree to release, hold harmless and indemnify the **BRIGHT HORIZONS THERAPEUTIC RIDING CENTER,** its officers, directors, trustees, agents, employees, representatives, successors and assigns, from all manner of liability, loss, costs, claims, demands and damages of every kind and nature whatsoever, including but not limited to reasonable attorneys fees, which the undersigned or said minor may now or in the future have against the **BRIGHT HORIZONS THERAPEUTIC RIDING CENTER, Walker Farms,** its officers, directors, trustees, agents, employees, representatives, successors and assigns, on account of any accident, damage, injury or illness, physical or mental condition, known or unknown, to the undersigned or said minor, or the treatment thereof, arising as a result of, or in any way connected to acts or incidents occurring at or relating to the **BRIGHT HORIZONS THERAPEUTIC RIDING CENTER, Walker Farms,** its officers, directors, trustees, agents, employees, representatives, successors or assigns, including but not limited to their negligence or gross negligence in rendering the services described above or in any way incidental thereto.

Date_____

Participant Name (Print) _____

Participant or Parent/Guardian Signature_____

Print Parent/Guardian Name _____

Relationship to Participant_____

Address_____

City _____ State_____ Zip_____

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PHOTO RELEASE

PHOTO RELEASE

PLEASE CHECK ONE: ____ **I DO** or ____ **I DO NOT** consent to and authorize the use and reproduction by Bright Horizons Therapeutic Riding Center of any and all photographs and any other audio/visual materials taken of me/my child for promotional material, educational activities, exhibits, social media or for any other use for benefit of the program.

With respect to the foregoing matters, no inducements or promises have been made to me/us to secure my/our signature(s) to this release other than the intention of Bright Horizons Therapeutic Riding Center and its work.

Print Participant Name_____

Print Parent /Guardian Name

(If Applicable)_____

Address _____

City _____State_____ Zip Code_____

Participant/Parent/Guardian Signature: _____

DATE _____

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POSSIBLE REASONS FOR PATIENT/CLIENT DISCHARGE

Please be advised of the following reasons that may lead to discharge from the therapy program and/or from the Bright Horizons Therapeutic Riding Center. The duration of therapy treatment time is variable, however at some point **all clients will be discharged from therapy**. It is determined at the time of discharge from the therapy program options to transfer to sport riding program or the possible discharge from the Bright Horizons Therapeutic Riding Center entirely.

1. Participant is determined to have a contraindication to Equine Assisted Activities, as defined by PATH, Intl. (Professional Association of Therapeutic Horsemanship) Standards.
2. Participant has a precaution, as defined by PATH, Intl. Standards, that Bright Horizons is not able to make special accommodations for.
3. Participant's potential to maintain head and neck control in sitting presents a safety concern.
4. Inability to follow directions is interfering with progress toward treatment goals.
5. Uncontrolled and inappropriate behavior that constitutes a safety risk to patient/client and/ or staff.
6. Participant exceeds weight that can safely be managed by staff, volunteers, and/or therapy horses.
7. Any change in the patient's/client's medical, physical, cognitive, or emotional condition that makes therapeutic riding, Interactive Vaulting, or Equine Assisted Learning inappropriate.
8. Three scheduled sessions are missed without prior canceling, at the discretion of the treating therapist and/or instructor.
9. Non payment of billed funds after 90 days

Signature of Participant or Parent/Legal Guardian:

_____Date:_____

Bright Horizons Therapeutic Riding Center
Participant's Medical History and 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:_____ Indwelling Catheter Present? Y N
Special Precautions/Needs:_____
Mobility (Circle one): Independent Ambulation Assisted Ambulation Wheelchair Braces/Assistive Devices:_____
For Participants with Down Syndrome: Neurologic Symptoms of Atlanto Axial Instability?
___Present____Absent Date of last exam:_____

Please indicate current or past special needs in the following systems/areas, including surgeries, as these conditions may suggest precautions and contraindications to equine activities:

	Y	N	If yes, comments:
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary / Skin			
Immunity			
Pulmonary			
Neurologic			
Paralysis			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that Bright Horizons Therapeutic Riding Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Bright Horizons Therapeutic Riding Center for ongoing evaluation to determine eligibility for participation.

Name/Title:_____ MD DO NP PA Other_____
Signature:_____Date:_____
Address:_____
Phone (_____)_____ License/UPIN Number:_____