Seaside Therapeutic Riding Inc.

3903 Nostrand Ave
Suite LL-3
Brooklyn, N.Y. 11235
Phone (718) 812-8466
Fax (718) 332-7992
Daniel Cutler, Director

REGISTRATION AND RELEASE FORM

E-mail address ________________________

Rider's Name ____________________ **Date of Birth:** ____/____/____ **Age** ______

Weight: _________ **Height:** ______ **Disability:** _____________________________

Parent/Guardian Name: _______________________ **E-mail** _______ ____________

Street: ________________________ **City:** __________ **State:**______ **Zip:** ________

Home Phone: ( ) _________________ **Business Phone: ( )** _________________

Business Name: _________________________ **Address** _____________________

Emergency contact person: ________________________ **Phone ( )** ___________

School or institution presently attending

____

Teacher's Name: ____

PHOTO RELEASE:

_____ **I hereby consent to and authorize**

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

the use and reproduction of any and all photographs and other audiovisual materials taken of me by Seaside Therapeutic Riding for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the program

Date: ___________ **Signature:** ____

Seaside Therapeutic Riding Inc.

LIABILITY RELEASE (Required):

__________________________ (Name) would like to participate in the Seaside Therapeutic Riding program. I acknowledge the risks and potential for risks of horseback riding including grievous bodily harm. However, I feel that the possible benefits to me/ my child/ my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors, and administrators, waive and release forever all claims for damages against Seaside Therapeutic Riding Instructors, Therapists, Aides, Volunteers, and /or Employees for any and all injuries and /or losses I/my child/my ward may sustain while participation in the Program from whatever cause. The undersigned acknowledges that he/she has read this Registration and Release Form in its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.

Date: _____________ Signature ________________________________

TESTING RELEASE (NEW RIDERS ONLY): I have read the letter to prospective Seaside Therapeutic Riding, riders, parents, and /or teachers. I understand the importance of pre- and post- testing of new riders. I give permission for ________________________________ to be tested by Seaside Therapeutic Riding Inc.

Date: ____________ Signature: ____

Seaside Therapeutic Riding

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

_____ Participant _____ Staff _____ Volunteer

Name: ______________________________ DOB: _________ Phone: _______________

Address: ___________________________________ City ________________

State: _________ Zip: _________

Physician's Name: __________________________________

Preferred Medical Facility: ____

Health Insurance Co. ______________________________________

Policy # __________________________

Allergies to Medications: ____

Current Medications:

____

____

Current Health Concerns:

____

____

____

In the event of an emergency, contact:

Name: _________________________ Relation: ___________________ Phone: _______________

Name: _________________________ Relation: ___________________ Phone: _______________

Name: _________________________ Relation: ___________________ Phone: _______________

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services from Seaside Therapeutic Riding Inc.,

I authorize Seaside Therapeutic Riding Inc. 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.**

Seaside Therapeutic Riding Inc.

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(s) listed above cannot be reached

Date: _____________ Consent Signature: _________________________________

(Client, Parent, or Legal Guardian)

NON-CONSENT PLAN

I do not give 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 JAMAICA BAY RIDING ACADEMY In the event emergency treatment/aid is required, I wish the following procedures to take place:

____

____

____

Date: ______________ Non-Consent Signature: ____________________________________

(Client, Parent, or Legal Guardian, Sign in Present of Seaside Therapeutic Riding Staff)

Seaside Therapeutic Riding Inc.

3903 Nostrand Ave
Suite LL-3
Brooklyn, N.Y. 11235
Phone (718) 812-8466
Fax (718) 332-7992
Daniel Cutler, Director

www.SeasideRiding.com

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant: ____ **DOB:** _______ **Height:** ________

Address: ____ **Weight:** ________

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: ____________________________________

Special Precautions/Needs: ____

____

Mobility:

Independent Ambulation? Y N

Assisted Ambulation: Y N

Wheelchair: Y N

Braces/Assistive Devices: ____

For those with Down Syndrome: **AtlantoDens Interval X-rays, Date ___________ Result: + -**

Neurologic Symptoms of AtlantoAxial Instability: ____

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Seaside Therapeutic Riding r will weigh the medical information above against the existing precautions and contraindications. I concur with a referral of the patient to a licensed/credentialed health professional (e.g. PT, OT SPEECH, PSYCHOLOGIST, ETC) in the implementations of an effective equestrian program

Name/Title: ___________________________________ MD DO Other _____________

Signature: ____________________________________ Date: ____________________

Address: ____

Phone: ____________________________ License/UPIN Number _______________