SDTR
PARTICIANT APPLICATION

Participant's Name: _____ DOB: _____

Street: _____ C/S/Z: _____

Main Contact Phone: _____

E-Mail Address: _____ Cell Phone: _____

Height: _____ Weight: _____ Age: _____

Emergency Information

Parents or Guardian: _____

Address/Phone (if different): _____

Employer/School (of client): _____

Caregiver (if applicable): _____ Phone: _____

E-Mail Address: _____ Okay to contact: Y N

PHOTO RELEASE: (Please indicate your preference by signing your consent or non-consent)

I authorize the use a reproduction by SDTRHR, Inc. of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the program.

I **consent** to use of photographs:

Date: _____ Signature: _____
(Participant, Parent or Guardian)

I **do NOT** consent to use of photographs

Date: _____ Signature: _____
(Participant, Parent or Guardian)

Do you have any conditions which might be affected by the weather (heat, cold), the environment (insect allergies, asthma, dirt) or the animals (allergies)?

_____

_____

_____

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

FUNCTION (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus equipment)

_____

_____

_____

SOCIAL (i.e. Work/school including grade completed, leisure interests, relations-family structure, support systems, companion animals, fears/concerns, ect.)

_____

_____

_____

Please describe nature of disability: _____

_____

_____

Is there an extreme involvement, please indicate and describe: _____

_____

_____

Check mobility level:

_____Walks unassisted

_____Walks assisted

_____Wears braces

_____Uses crutches

_____Uses walker

_____Uses wheelchair

Can sit erect without support straps? : Y N

Getting to know you!

Please fill out this page for out Participant Notebook. The Participant Notebook is for the volunteers to get to know a little about the riders they will be working with.

_____
Date

Picture
(Optional)

My full name is _____

Please call me _____. My birth date is _____.
(name I go by)

I began riding at SDTR on _____.

Family members: _____

Pets: _____

My interests or hobbies are: _____

My goals for riding therapy are: _____

(Optional) Please supply any details about the participant you think might be helpful to the volunteers who will be working with him/her/you. (Speech, Vision, Comprehension)

_____

_____

_____

(Optional) Particular methods that this participant responds to: _____

_____

_____

SDTR
WAIVER AND RELEASE OF LIABILITY

Name of Participant (print): _____

I acknowledge that horseback riding or activities involving horse is an extreme test of a person's physical and mental limits and carries with it the potential for serious injury, personal property loss or even death. Horses are large animals and even the most quiet and calm horse can be unpredictable. I hereby assume the risk of participating in such activities.

I hereby take the following action for myself and my executors, administrators, heirs, next of kin, successors and assigns:

a) I waive, release and discharge from any and all claims or liabilities for death, personal injury or damages of any kinds, which acts arise out of or relate to my participation in, or my traveling to and from, the horseback riding events, the following persons or entities: SDTRHR, building or facility lessees, sponsors, and the officers, directors, employees, representatives, instructors and agents of the above.
b) I agree not to sue any of the person or entities mentioned above for any of the claims or liabilities that I have waived, released or discharged herein, and
c) I indemnify and hold harmless the persons or entities mentioned above form any claims made or liabilities assessed against them as results of my actions and any attorney fees or costs incurred by them as a result of my action.

By signing this form, I affirm that I am eighteen (18) years of age or older, I have read this document, and I understand its contents.

_____ _____

Signature of Participant (Parent/Guardian if minor) *Date Signed*

The undersigned (parent/guardian's name: _____the parent and natural or legal guardian or (minor's name: _____hereby executes the foregoing Wavier and Release for and on behalf of the minor named herein. I hereby bind myself and all other assigns to the terms of the Waiver and Release. I represent that I have the legal capacity and authority to act for and on behalf of the minor name herein, and I agree to indemnify and hold harmless the persons and entities mentioned above for any claims for liabilities assessed against them as a result of any insufficiency of my legal capacity or authority to act for on or behalf of the minor in the execution of Waiver and Release.

_____ _____

Signature of Parent/Guardian *Date Signed*

Southern Delaware Therapeutic & Recreational Horseback Riding Inc.
Authorization for Emergency Medical Treatment Form

☐ Participant ☐ Staff ☐ Volunteer

Name: _____ Date: _____

Phone: Home: (_____)_____ Work: (_____)_____

Address: _____

Physician Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to Medications: _____

Current Medication & Dosage: _____

Describe and disability/medical condition requiring special precautions or treatment: _____

_____

In the event of an emergency, contact:

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 or while being on the property of the agency, I authorize SDTRHR to:

1) Secure and retain medical treatment and transportation if needed.
2) Release any records upon request to the authorized individual or agency involved in the medical emergency treatment.

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) above is unable to be reached.

Consent Signature: _____ Date: _____

Participant/Parent or Legal Guardian

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:

_____

_____

Signature: _____ Date: _____

Participant/Parent or Legal Guardian

Print Name: _____

SDTR
Precautions & Contraindications

Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Othropedic

Atlantoaxial Instability – include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossification
Joint subluxation/dislocation
Osteoporosis
Pathological Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia

Other

Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – e.g., 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 (e.g., RA, MS)
Fire Setting
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding the patient's participation in therapeutic equine activities, please feel free to contact SDTRHR at **(302) 644–1920**.