

SDTRHR  
STUDENT APPLICATION

Student's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street: \_\_\_\_\_ C/S/Z: \_\_\_\_\_

Main Contact Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_

Emergency Information

Parents or Guardian: \_\_\_\_\_

Address/Phone (if different): \_\_\_\_\_

Employer/School (of client): \_\_\_\_\_

Caregiver (if applicable): \_\_\_\_\_ Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Okay to contact: \_\_\_\_\_

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

I authorize the use and 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: \_\_\_\_\_  
Student, Parent or Guardian

I do NOT consent to use of photographs

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Student, 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)?

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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 riding)

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

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Please describe nature of disability: \_\_\_\_\_

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Is there an extremity involvement, please indicate and describe: \_\_\_\_\_

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Check mobility level:

\_\_\_\_\_ Walks unassisted

\_\_\_\_\_ Uses crutches

\_\_\_\_\_ Walks assisted

\_\_\_\_\_ Uses walker

\_\_\_\_\_ Wears braces

\_\_\_\_\_ Uses wheelchair (can sit erect without support straps? Y or N)

# GETTING TO KNOW YOU!!!

Please fill out this page for our Rider Notebook. The Rider 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 SDTRHR on \_\_\_\_\_(date).

Family members: \_\_\_\_\_

Pets: \_\_\_\_\_

My interests or hobbies are \_\_\_\_\_

My goals for riding therapy are \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Optional) Particular methods that this student responds to: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

SDTRHR  
WAIVER AND RELEASE OF LIABILITY

Name of Student (please print): \_\_\_\_\_

I acknowledge that horseback riding or activities involving horses 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 persons 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 from 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 Student (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 Waiver 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 named herein, and I agree to indemnify and hold harmless the persons and entities mentioned above for any claims or 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 the Waiver and Release.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date Signed

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

- q Participant
- q Staff
- q Volunteer

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone: Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Current Medication & Dosage: \_\_\_\_\_

Describe any 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:

- 2) 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: \_\_\_\_\_  
Student/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: \_\_\_\_\_  
Student/Parent or Legal Guardian

Print Name: \_\_\_\_\_

SDTRHR  
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.

ORTHOPEDIC

Atlantoaxial Instability  
*Include neurological Symptoms*  
Coxa Arthrosis  
Cranial Deficits  
Heterotopic Ossification/Myositis Ossificans  
Joint subluxation/dislocation  
Osteoporosis  
Pathological Fractures  
Spinal Fusion/Fixation  
Spinal Instability/Abnormalities

NEUROLOGIC

Hydrocephalus/Shunt  
Seizure  
Spina Bifida/Chiari II malformation/Tethered  
Cord/Hydromyelia

OTHER

Age-Under 3 years  
Indwelling Catheters  
Medications-i.e. photosensitivity

MEDICAL/PSYCHOLOGICAL

Allergies  
Animal Abuse  
Physical/Sexual/Emotional Abuse  
Blood Pressure Control  
Dangerous to self or others  
Exacerbations of medical conditions  
Fire Settings  
Heart Conditions  
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 this patient's participation in therapeutic equine activities, please feel free to contact SDTRHR at (302) 422-5291.