Reining Hope Adaptive Equine Assisted Activities & Therapies LLC

574 Sunset Drive
PO Box 146
Morgan, VT 05853
Tel: 802.895.9166 Fax: 802.895-9177 Web: www.reininghopeaeaat.com
"Wish It, Dream It, Do It!"

Reining Hope 2018 Summer NCUJHS Youth Horsemanship Program
APPLICATION AND RELEASE FORM

Name: _____ Date of Birth: ___/___/___ Age: _____

Weight: _____ Height: _____ Disability/Diagnosis/Pertinent Information (if any): _____

_____

Parent/Guardian Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: (H)_____(C)_____(W)_____

Email: _____

Emergency Contact Person #1: _____ Phone: _____

Emergency Contact Person #2: _____ Phone: _____

Has the rider participated in the Reining Hope Program before? _____Yes _____ No If Yes, When? _____
Please describe the riding skill: Never Ridden _____ Beginner _____
Intermediate _____ Advanced (able to walk/trot/canter independently) _____

Session Dates/Times:

Monday, July 23rd through Friday, July 27th ~ 8:30am to 2:30pm

~ Registration Deadline ~ June 5th, 2017

If your first choice is filled and/or you wish to participate in more than one session, please indicate order of preference:
_____

Rider's T-Shirt Size: Child's - Small _____ Medium _____ Large _____
Adult's - Small _____ Medium _____ Large _____

PHOTO RELEASE: _____ I hereby consent to and authorize
_____ I do not consent to nor authorize
The use and reproduction by Reining Hope AEAAT LLC of any and all photographs and other audiovisual materials taken of me for promotional printed material, educational activities, exhibitions or for other use for the benefit of the program.

LIABILITY RELEASE (Required): I, _____ (Name of Rider/Participant), would like to participate in the Reining Hope AEAAT LLC Program. I acknowledge the risks and potential for risks of horseback riding and other equine-assisted activities including grievous bodily harm. However, I feel that the possible benefits to myself/my child/my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors, administrators, waive and release forever all claims for damages against Reining Hope AEAAT LLC, its Members, Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my child/my ward may sustain while participating in the Program from whatever cause including but not limited to the negligence of these related parties.

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 of Parent/Guardian: _____

Release of Liability & Hold Harmless Release Form

Reining Hope AEAAT, LLC
574 Sunset Drive
Morgan, VT 05853

Release of Liability and Hold Harmless Agreement

I, _____ (participant/volunteer/boarder), and _____ (parent if participant/volunteer/boarder is a minor) understand and accept the risks and rules below:

I understand that the handling, use and riding of a horse involves the risk of injury or death. I also understand that under Vermont Law, an equine activity sponsor is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities that are obvious and necessary, pursuant to 12 V.S.A 1039. With full knowledge of these and all other dangers inherent to the sport of horseback riding and equine activities, I am knowingly participating in boarding/riding and or training at Reining Hope AEAAT, LLC and voluntarily engage myself, and/or my minor child) in these activities and fully assume all risks involved.

I understand that I must follow the policies and safety rules of Reining Hope AEAAT, LLC when at these premises.

I agree to fully and forever release and hold harmless Reining Hope AEAAT, LLC its employees, owners, riding instructors, the Mason/Roberge family and other agents acting on behalf from any and all liabilities due to injuries, claims, damages, actions, or losses, which may arise out of my, my minor child's, or my guest's presence at Reining Hope AEAAT, LLC or the boarding or handling of my horse, including without limitation this farm's ordinary negligence in the operation of the farm.

I shall bring no claims, demands, actions, or litigation against Reining Hope AEAAT, LLC, its owners, employees, riding instructors, and other agents acting on behalf or for Reining Hope AEAAT, LLC for any economic losses and non economic losses due to bodily injury, death, or property damage, sustained by me or my minor child (if applicable) in relation to the premises and operations of this stable.

I HAVE READ AND UNDERSTAND THIS ENTIRE LIABILITY RELEASE

_____ _____

Signature of participant/volunteer/boarder, Date Signature of parent and/or legal guardian, Date

Print Name: _____

Address _____

Phone _____

Email _____

Reining Hope Adaptive Equine Assisted Activities & Therapies LLC

574 Sunset Drive
PO Box 146
Morgan, VT 05853
Tel: 802.895.9166 Fax: 802.895-9177 Web: www.reininghopeaeaat.com
"Wish It, Dream It, Do It!"

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

_____Participant _____Staff _____Volunteer

Name: _____ DOB: _____ Phone: _____
Physician's Name: _____ Preferred Medical Facility: _____
Health Insurance Co: _____ Policy #: _____
Current Allergies, Medications and Health Concerns: _____

In the event of an emergency:
Emergency Contact 1: _____ Relation: _____
Home Ph: _____ Work Ph: _____ Cell Ph: _____
Emergency Contact 2: _____ Relation: _____
Home Ph: _____ Work Ph: _____ Cell Ph: _____

In the event that an 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 REINING HOPE AEAAT LLC 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.

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 as emergency contact(s) 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 the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place (please give details below):

Date: _____ Non-Consent Signature: _____
Client, Parent or Legal Guardian

Reining Hope Adaptive Equine Assisted Activities & Therapies LLC

574 Sunset Drive
PO Box 146
Morgan, VT 05853
Tel: 802.895.9166 Fax: 802.895-9177 Web: www.reininghopeaeaat.com
"Wish It, Dream It, Do It!"

Date: _____

Dear Physician:

Your patient, _____ (participant's name) is interested in participating in supervised equestrian activities.

In order to safely provide this service, our center requests that you complete/update the attached (please see reverse) Medical History and Physician's Statement form. Please note that the following conditions may suggest precautions and/or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present and to what degree.

Orthopedic	**Medical/Psychological**
Atlantoaxial Instability – include neurological symptoms	Allergies
Coxa Arthrosis	Animal Abuse
Cranial Deficits	Physical/Sexual/Emotional Abuse
Heterotopic Ossification/Myositis Ossificans	Blood Pressure Control
Joint Subluxation/Dislocation	Dangerous to self or others
Osteoporosis	Exacerbations of medical condition(s)
Pathological Fractures	Fire Settings
Spinal Fusion/Fixation	Heart Conditions
Spinal Instability/Abnormalities	Hemophilia
	Medical Instability
Neurologic	Migraines
Hydrocephalus/Shunt	PVD
Seizure	Respiratory Compromise
Spina Bifida/Chiari II Malformation/Tethered Cord/ Hydromyelia	Recent Surgeries
	Substance Abuse
Other	Thought Control Disorders
Age – usually under 4 years	Weight Control Disorders
Indwelling Catheters	
Medications, i.e. photosensitivity	
Poor Endurance	
Skin Breakdown	

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 the center at the address/phone number indicated above.

Sincerely,

Kristin E. Mason, Program Director

(Please complete information on other side)

PARTICIPANT'S MEDICAL HISTORY & 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: _____
Special Precautions, Diets/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:** + --
Neurological Symptoms of AtlantoAxial Instability: _____
_____May participate in all activities; _____May participate except for: _____

This participant/patient is up-to-date on all the following routine childhood immunizations:

	Y	N	Date:
Measles			
Rubella			
Tetanus			
Pertussis			
Polio			
Diphtheria			
Other:			

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			

IMPORTANT NOTE TO DOCTOR/MEDICAL FACILITY:

If you prefer to provide the requested information on your own medical form, we will accept that only when the below release section is completed, signed & dated and your form is stapled to our form.

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center 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, SLT, Psychologist, etc) in the implementations of an effective equestrian program.

Name/Title: _____ **MD DO Other:** _____
Signature: _____ **Date:** _____
Address: _____
Phone: _____ **License/UPIN Number:** _____