TAKE IN INFORMATION / APPLICATION FOR SERVICES

Participant: _____ Date of Birth: _____
Parents or Legal Guardian:

_____
Complete Mailing Address:

_____

_____
Phone # Home: _____ Cell #: _____
E-mail address: _____
Treatment Request/ Frequency: _____

Please describe the participant's challenges: _____

_____

What are the participant's emotional reactions in a stressful situation? Does the participant withdraw, show aggression or become tearful? _____

_____

What benefits do you hope the participant will gain from this program?

_____

_____

Is the participant a "movement seeker" or a "movement avoider"?

_____

_____

What affects the participant's attention? Does the participant perseverate or become distractible, inattentive, and impulsive?

_____

_____

Please state three different goals that the client would like to accomplish this year. (Must be completed)

1._____

2._____

3. _____

BARN RULES

- SMOKING IN BARN OR ANYWHERE ON PREMISES IS NOT ALLOWED. IF YOU SEE SOMEONE SMOKING PLEASE ASK HIM/HER TO STOP.
- PLEASE DO NOT FEED THE HORSE(S). TREATS MAY BE GIVEN WITH THE SUPERVISION OF AN INSTRUCTOR OR HORSE HANDLER.
- ALL STUDENTS AND NON-BOARDERS NEED TO BE ACCOMPANIED BY AN INSTRUCTOR OR HORSE HANDLER BEFORE ENTERING PADDOCKS, PASTURES, OR STALLS.
- DOGS ARE NOT ALLOWED UNLESS THEY ARE SERVICE DOGS.
- IF YOU PLAN TO BRING GUESTS TO THE BARN, PLEASE BE AWARE OF THEIR WHEREABOUTS.
- ALL RIDERS (INCLUDING GUESTS) MUST SIGN A *RIDER RELEASE FORM* BEFORE RIDING ANYWHERE ON THE PREMISES.
- PLEASE NOTIFY STAFF OF ANY LESSONS CHANGED OR CANCELLED FOR SCHEDULING PURPOSES.
- **ALL LADAWN QUARTER HORSES THERAPEUTIC RIDING CLIENTS ARE REQUIRED TO WEAR AN ASTM/SEI APPROVED RIDING HELMET AND PROPER PROTECTIVE FOOTWEAR WITH A RIDING HEAL.**

SIGNED, SEEN, AND AGREED ON _____, BY THE FOLLOWING:
(DATE)

_____

(STUDENT/PARENT/GUARDIAN)

LIABILITY RELEASE

As a participant at LADAWN QUARTER HORSES THERAPEUTIC RIDING CENTER, I acknowledge the risks and potential for risks of a horseback riding program. However, I feel that the possible benefits are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against LADAWN QUARTER HORSES THERAPEUTIC RIDING CENTER, its board of directors, instructors, therapists, volunteers and/or employees for any and all injuries and/or losses I may sustain while participating at LADAWN QUARTER HORSES THERAPEUTIC RIDING CENTER.

No person can be accepted for riding instruction/intervention, until this form has been completed by the parent/parents or guardian. Yes, I would like _____ to participate in the riding program, and I have discussed this with the rider's Doctor. I understand that riding instruction will be under strict supervision, and although every effort will be made to avoid an accident; No Liability can be accepted by any organizations concerned, including LADAWN QUARTER HORSES and/or LADAWN QUARTER HORSES THERAPEUTIC RIDING CENTER.

SIGNATURE_____ DATE_____

SIGNATURE OF PARENT/GUARDIAN _____DATE_____

Emergency options:

CONSENT PLAN

In case of emergency, I authorize LADAWN QUARTER HORSES THERAPEUTIC RIDING CENTER to secure medical treatment including x-ray, surgery, hospitalization and medication and any treatment procedure deemed "life saving" by the physician. THIS PROVISION WILL BE INVOLKED ONLY IF THE PERSON(S) BELOW ARE UNABLE TO BE REACHED. AUTHORIZATION INCLUDES:

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.

DATE_____ SIGNATURE_____

IN CASE OF EMERGENCY CONTACT:

NAME _____ PHONE _____RELATION_____
NAME _____ PHONE _____RELATION_____
NAME _____ PHONE _____RELATION_____
HEALTH INSURANCE COMPANY_____
POLICY#_____
ALLERGIES TO MEDICATIONS:

_____
CURRENT MEDICATIONS: _____

PHYSICIAN _____ PREFERRED MEDICAL FACILITY_____
DATE OF LAST TETANUS SHOT: _____
TUBERCULOSIS TEST + - DATE: _____

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 THAT EMERGENCY TREATMENT/AID IS

REQUIRED, I WISH THE FOLLOWING PROCEDURE TO TAKE PLACE:

_____

_____

DATE_____ SIGNATURE_____