PARTICPANT REGISTRATION AND RELEASE FORM

PARTICPANT NAME_____ DOB: _____

GENDER: M F WEIGHT _____ HEIGHT _____ SCHOOL/GROUP_____
ADDRESS: _____ CITY: _____ ZIP: _____
HOME PHONE: (___)_____ WORK PHONE: (___)_____ EMERGENCY (____)_____
PARENTS OR GUARDIAN_____
ADDRESS(if different from above): _____
Phone:_____ Email:_____
HAS STUDENT EVER RIDDEN A HORSE: YES NO
How did you hear about the program?: _____

For Office Use Only
Date Rec'd _____

Helmet Size_____

HEALTH HISTORY

Diagnosis: _____

MOBILITY:
INDEPENDENT AMBULATION _____YES _____ NO
ASSISTED AMBULATION _____ YES _____ NO
WHEELCHAIR _____YES _____ NO
BRACES/ASSISTIVE DEVICES _____
SPECIAL PRECAUTIONS/NEEDS:_____
TETNAUS SHOT: Yes ____ No____ Date ____

Please indicate current or past special needs in the following areas:

	Y	*N*	*Comments*
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			
Other			

MEDICATIONS (include prescription, over-the-counter; name, dose and frequency) _____

_____

_____

_____

_____

GOALS (i.e. why are you applying for participation? What would you like to accomplish?

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

Please check the box next to each of these terms if you agree.

☐ **Participant Liability Release**

As a rider at *Riding For Dreams Therapeutic Riding Program* I acknowledge the risks and potential for risks of a horseback riding program. However, I feel that the possible benefits to myself and the clients I work with are greater than the risk. Thereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, released forever all claims for damages against *Riding For Dreams Therapeutic Riding Program*, its Board of Directors, instructors, volunteers and/or employees for any and all injuries and/or losses I may sustain while participating at *Riding For Dreams Therapeutic Riding Program*. *Riding For Dreams Therapeutic Riding Program* also falls under the North Dakota Statutes NDCC 53-10-01 and NDCC 53-10-02. *(The summary of the North Dakota Equine Century Codes are found under the Riding For Dreams Policies and Procedures.)*

Photo Release

I ☐ DO

☐ DO NOT

Consent to and authorize the use and reproduction by *Riding For Dreams Therapeutic Riding Program* of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program. This is valid for one year and can be revoked at my request in writing.

☐ **Policies and Procedures**

I have read the attached instructions and fully understand the policies, standards and rules put in place by *Riding For Dreams Therapeutic Riding Program* and agree to comply with them as stated. This is valid for one year and cannot be revoked.

Physicians Signature Required Below

☐ **Participants Consent for Release of Information**

I hereby authorize: _____
(person or facility)

to release information from the records of: _____ DOB: _____
(participant's name)

The information is to be released to: *Riding For Dreams Therapeutic Riding Program* for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

- o Medical history
- o Physical therapy evaluation, assessment and program plan
- o Speech therapy evaluation, assessment and program plan
- o Mental health diagnosis and treatment plan
- o Individual Habilitation Plan (I.H.P.)
- o Classroom Individual Education Plan (I.E.P.)
- o Psychosocial evaluation, assessment and program plan
- o Cognitive-behavioral management plan
- o Other: _____

Please provide such records to Riding For Dreams before your child's first lesson starts. This release is valid for one year and can be revoked, in writing, at my request.

By signing this form you are agreeing to these terms set forth between you, your child and Riding For Dreams Therapeutic Riding Program.

Signature: _____ Date: _____

Print Name: _____Relation to Participant: _____

******FOR PERSONS WITH DOWN SYNDROME: Because of the nature of the horseback riding activity, no individual with Down Syndrome can be accepted for riding instruction without proof of negative diagnostic X-ray for Alantoaxial Dislocation Condition.***

_____ NEGATIVE CERVIVAL X-RAY FOR ATLANTOAXIAL INSTABILITY. X-RAY DATE _____

_____ NEGATIVE FOR CLINICAL SYMPTOMS OF ATLANTOAXIAL INSTABILITY.

☐ **HEALTH CARE PROVIDER'S SIGNATURE**

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 review of the person's abilities/limitations by a licensed/credentialed health professionals in the implementing of an effective equestrian program.

Physician Name (Please print) _____Date_____

Physicians Signature_____

Address _____City _____ State _____ Zip _____

Phone_____

"Riding For Dreams Therapeutic Riding Program"
PO Box 911
Lisbon, ND 58054
701-683-4619
www.ridingfordreams.org
ridingfordreams@hotmail.com

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3/30/2017

Dear Health Care Provider,

Your patient _____ is interested in participating in supervised equine activities at Riding For Dreams Therapeutic Riding Program.

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

Orthopedic
Atlantoaxial Instability- include neurologic symptoms
Coxarthrosis
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osterporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifidia/Chiari II Malformation/Tethered Coed/Hydromyelia

Other
Age- Under 4 years
Indwelling Catheters/Medical Equipment
Medications- e.g., Photosensitivity
Poor Endurance or 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 this patient's participation in equine-assisted activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,

Stacy Erdmann
Riding For Dreams Registered Riding Instructor
701-680-1224

Laurie Bischof
Riding For Dreams Registered Riding Instructor
701-680-1233

Citation: NDCC 53-10-01; NDCC 53-10-02

Summary: This North Dakota statute provides that an equine activity sponsor or an equine professional is not liable for an injury to or the death of a participant engaged in an equine activity and no participant may maintain an action against an equine activity sponsor or professional. Statutory definitions are provided, including "participant," "equine activity," and who is considered an "equine sponsor" or "equine professional." Liability is not limited by this statute where the equine professional knowingly provided faulty tack or equipment, failed to make reasonable and prudent efforts to determine the ability of the participant to engage safely in the equine activity, owns or otherwise is in lawful possession of the land or facilities upon which the participant sustained injuries because of a known, dangerous latent condition, or if he or she commits an act or omission that constitutes willful or wanton disregard for the safety of the participant or intentionally injures the participant