**Exceptional Equestrians of the Missouri Valley, Inc.** 

**785 Yellow Finch Lane Washington, MO 63090**

**Therapeutic Riding Program**

**2024 Participant Application**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ COUNTY: \_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BIRTH DATE: \_\_\_\_\_\_\_\_\_\_\_ ETHNICITY: \_\_\_\_\_\_\_\_\_\_\_\_ HEIGHT: \_\_\_\_\_\_ in. WEIGHT\_\_\_\_\_\_\_lbs.

GENDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ PREFERRED PRONOUN: HE/HIM, SHE/HER, THEY/THEM

**If the participant is less than 18 years of age, the parent or legal guardian should fill in below:**

Emergency Contact or

Parent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Parent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Name and Address of **Legal Guardian** (if different from participant or parent)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (phone) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Address of **Caregiver** (if different from participant or parent)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (phone) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participant receives service coordination from (please circle if applicable):**

Compass Health Franklin Country SB40 Resource Board

Warren County Developmental Disabilities Board Gasconade County Board

Other: please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Yes, Name of Service Coordinator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Not currently receiving service coordination, but am interested.

Please contact me with more information \_\_\_\_ (check line if applicable)

School Name/Occupation/Day program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle if the participant receives additional medical services**

Physical Therapy Occupational Therapy Speech Therapy Mental Healthservices

If Yes, Name of Service Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participant Profile**

Participant has previously participated in equine assisted activities and therapies \_\_Yes \_\_No

If Yes, Please check all that apply: at EEMV\_\_\_\_ at another center (specify)\_\_\_\_\_ how many years\_\_\_\_\_

**Participant is (please circle):** Ambulatory Non- ambulatory Verbal Non- verbal

**Participant uses (circle):** Wheelchair Crutches Braces Walker Cane

Speech-generating device (eg-Dynavox) PECS Cards Sign Language Other\_\_\_\_\_\_\_\_\_

Participant is able to sit independently: Yes No

**How did you hear about Exceptional Equestrians?**

EF Scanned

**Exceptional Equestrians of the Missouri Valley, Inc.**

785 Yellow Finch Lane, Washington, MO 63090

phone: 636-390-2141 fax: 636-900-9007

**CONSENT FOR RELEASE OF INFORMATION:**

I hereby authorize\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(facility, individual, physician, etc.) to release information from the records of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(participant name) to Exceptional Equestrians of the Missouri Valley, Inc. for the purpose of developing a therapeutic riding program for the above-named participant. The information to be released is marked below. (Please make as many copies of this form as necessary for any additional releases needed.)

\_\_\_\_\_\_\_\_Medical History

\_\_\_\_\_\_\_\_Physical Therapy evaluation, assessment and program plan

\_\_\_\_\_\_\_\_Occupational Therapy evaluation, assessment and program plan

\_\_\_\_\_\_\_\_Speech Therapy evaluation, assessment and program plan

\_\_\_\_\_\_\_\_Classroom Individual Education Plan (I. E. P.)

\_\_\_\_\_\_\_\_Medical Insurance Provider, Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESEARCH DATA RELEASE**

The undersigned hereby grants permission to use all test results and scores obtained from evaluation, both formal and informal of above named rider while said rider was in attendance at programs associated with Exceptional Equestrians of the Missouri Valley, Inc. With regard to the foregoing statements, no use of the name of said individual will be included in published material. No promises have been made to me to secure my signature to this release other than the intention of Exceptional Equestrians of the Missouri Valley or associated programs or consultants to use the test results and scores obtained from evaluations for the purpose of educational work and research.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHOTO RELEASE**

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to Exceptional Equestrians of the Missouri Valley permission to take or have taken, still and moving photographs and films including television pictures of myself /son/ daughter /ward and / or pictures of parents /guardians / siblings and I consent and authorize Exceptional Equestrians of the Missouri Valley, Inc. its advertising agencies, news media and any other persons interested in Exceptional Equestrians of the Missouri Valley, Inc., PATH Int’l, AHA Inc. or other partners and supporters, and their work, to use and reproduce the photographs, films, and pictures to circulate and publicize the same by all means including without limitation the generality of the foregoing: newspapers, television media, brochures, pamphlets, instructional materials, books and clinical material.

With regard to the foregoing material, no inducements or promises have been made to me to secure my signature to this release other than the intention of Exceptional Equestrians of the Missouri Valley, Inc. to use or be used such photographs, films and pictures for the primary purpose of promoting and aiding Exceptional Equestrians of the Missouri Valley, Inc. and its work.

CONSENT: Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***ONLY SIGN HERE IF YOU DO NOT CONSENT TO PHOTOGRAPHY:***

NON-CONSENT SIGNATURE***:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***



**Exceptional Equestrians of the Missouri Valley**

785 Yellow Finch Lane, Washington, MO 63090

phone: 636-390-2141

fax: 636-239-7011

# **PARTICIPANT CONSENT, RELEASE AND INDEMNIFICATION AGREEMENT**

I/we, the parent(s) / guardian(s)\*\* of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(participant’s name), do hereby consent to and assume the unavoidable risks inherent in all horse related activities of said rider’s participation in the therapeutic horsemanship program sponsored by Exceptional Equestrians the Missouri Valley Inc., located at 785 Yellow Finch, Washington, Missouri and / or other locations. I acknowledge and I understand that despite reasonable safety precautions, horsemanship experiences can result in injury and even death. I also acknowledge my understanding that there are no assurances that said rider will receive physical or psychological benefits from participation in said program and I understand that the ordinary risks associated with horseback riding are increased by virtue of said rider’s disability.

I understand that UNDER MISSOURI LAW AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES PURSUANT TO THE REVISED STATUTES OF MISSOURI. I also understand that, in the event of any accident which might occur, NO LIABILITY can be accepted by any organization concerned, including Exceptional Equestrians of the Missouri Valley, Inc., its agents or assigns. In consideration, therefore, for the privilege of riding, and / or working around horses at Exceptional Equestrians, the Undersigned does hereby agree to hold harmless and indemnify Exceptional Equestrians of the Missouri Valley, Inc., and further release them from any liability or responsibility for accident, damage, injury, or illness to the Undersigned or to any horse owned by the Undersigned, or to any family member or spectator accompanying the Undersigned on the premises.

For and in consideration of the agreement of Exceptional Equestrians of the Missouri Valley, Inc. to provide riding instructions to the aforesaid rider, I do hereby forever release, acquit, discharge and hold harmless Exceptional Equestrians of the Missouri Valley, Inc., their officers, directors, agents, employees, instructors, representatives and any therapists, volunteers and other persons associated with said program and the successors and assigns of each of them from all manner of claims, demands and damages of every kind and nature whatsoever which I or the aforesaid rider may now or in the future have against Exceptional Equestrians of the Missouri Valley, Inc., their officers, directors, agents, employees, instructors, representatives and any therapists, volunteers and other persons associated with said program and the successors and assigns of each of them on account of any personal injuries, physical or mental condition, known or unknown, to the person of the aforesaid rider, and the treatment thereof, as a result of, or in any way growing out of the acts or omissions of said parties in connection with said services or in any way incidental thereto.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN RELEASE AND INDEMNIFICATION AGREEMENT**

I /We, the parent(s) / guardian(s)\* of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name of participant), acknowledge that I understand the medical authorization of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name of physician) does not constitute any assurance that the above named rider will receive physical or psychological benefits from the program conducted by Exceptional Equestrians of the Missouri Valley, Inc., nor does it constitute an assessment of the risk of possible injury to said rider in relation to the possible physical or psychological benefits to said rider from participation in the program.

In consideration of the services and the medical authorization of aforesaid physician, I hereby waive, release and relinquish any and all claims against him/her for any and all liability arising from his/her authorization for said rider to participate in the program offered by Exceptional Equestrians of the Missouri Valley, Inc. and I hereby agree to hold harmless and indemnify said physician against any and all claims arising from said authorization. Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exceptional Equestrians of the Missouri Valley**

785 Yellow Finch Lane, Washington, MO 63090

phone: 636-390-2141

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*Please note that registration is limited and filing paperwork does not necessarily guarantee a place in the Exceptional Equestrians of the Missouri Valley, Inc. program schedule.*

*\*In the event that you have sole legal custody of or are the sole living parent of the above named child /ward, only one signature is required, otherwise BOTH PARENTS OR GUARDIANS MUST SIGN prior to the child participating in the therapeutic riding program, Exceptional Equestrians of the Missouri Valley, Inc.*

**Your signature below indicates that you have read and understand all segments of this document.**

**Participant Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mother / guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Father / guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



    

EEMV Policy of Eligibility for Program Participants

Valid for sessions held between 1/1/2024 and 12/31/2024

The following criteria will be considered for any riders being accepted into the program:

* Those wishing to participate in EEMV sessions will be evaluated to determine if their medical, physical, and/or psychosocial diagnosis is within the precautions and contraindications guidelines as defined by the PATH Medical Committee. These precautions and contraindications are intended to ensure the safety of the clients.
* Students are given a scheduled session time only if there is an adequate number of staff and volunteers to safely serve them, an appropriate available time slot, a horse deemed acceptable by EEMV staff, and appropriate tack.
* Students must have all required forms completed and turned into the office at least 2 weeks prior to participation in EEMV lessons or activities.
* All students’ weights will be reviewed at the beginning of each riding session prior to classes and more frequently if necessary. This is to ensure they are properly and safely paired with a horse that is within the rider’s weight range. Students will be served by EEMV as long as there is a horse/pony that is suitable for them to be partnered with. If there is not one available, the student will put in a ground work class, if suitable, or put on the current wait list and can return to riding when there is a suitable horse available.
* Students may be served by EEMV if their attitude and behavior is deemed appropriate by their instructor or therapist to ensure safety for the student, staff, horse and volunteers.
* Students must be current in their payments owed to EEMV prior to each session starting in order to participate in lessons. Participants must have paid their invoice prior to their first class.
* Participants in Therapeutic Riding must be ages 4 and up. Licensed Therapy participants must be ages 2 and up.
* The participant is willing to wear required safety equipment (closed toe shoes, helmet, weather appropriate clothing, long pants).

By Signing below, I agree to and understand these terms.

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

Parent or Rider if over 18 Date

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

Participant’s Printed Name

**Exceptional Equestrians of the Missouri Valley, Inc.**

**785 Yellow Finch, Washington, MO 63090 Phone: (636) 390-2141 Fax: (636) 239-7011**

**Rider Medical History Form**

**\*\*\*\*\*MUST BE COMPLETED AND SIGNED BY PHYSICIAN!!!\*\*\*\*\***

Name of Rider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_

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

Name of Parent/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\* For persons with Down’s Syndrome:

\_\_\_\_\_\_ Negative Cervical X-ray for Atlanto-Axial Instability X-ray Date:\_\_\_\_\_\_

\_\_\_\_\_\_Negative for Clinical Symptoms of Atlanto-Axial Instability

\*\* If Seizures

Seizure type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Controlled?: \_\_\_\_\_\_\_\_Date of last seizure:\_\_\_\_\_\_\_

Tetanus shot: Date \_\_\_\_\_\_\_\_\_ (current tetanus required) Height\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_

Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

|  |  |  |  |
| --- | --- | --- | --- |
| Area | Yes | No | Comments |
| Allergies |  |  |  |
| Auditory |  |  |  |
| Visual |  |  |  |
| Cardiac |  |  |  |
| Circulatory |  |  |  |
| Pulmonary/Respiratory |  |  |  |
| Neurological |  |  |  |
| Muscular |  |  |  |
| Orthopedic |  |  |  |
| Learning Disability |  |  |  |
| Mental Impairment |  |  |  |
| Psychological Impairment |  |  |  |
| Other |  |  |  |
| Other |  |  |  |
| Other |  |  |  |

Mobility: Independent Ambulation: Y \_\_\_ N\_\_\_ Crutches: Y\_\_\_ N\_\_\_ Braces: Y\_\_\_ N\_\_\_ Wheelchair: Y\_\_\_ N\_\_

Precautions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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

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

**Physician Authorization**

I hearby give medical authorization for the above named rider to participate in Exceptional Equestrians of Missouri Valley, Inc. Therapeutic riding program which includes an evaluation by a licensed therapist and a certified therapeutic riding instructor to assess functional levels and recommend riding exercises. 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 this person’s abilities/limitations by a licensed/credentialed health professional (e.g. P.T., O. T., Speech Pathologist, Psychologist, etc.) in the implementing of an effective equestrian program. This authorization does not constitute any medical assurance that the person above named will receive physical or psychological benefits from the program conducted by Exceptional Equestrians of the Missouri Valley, Inc. Nor does it constitute an assessment of the risk of possible injury to said person in relation to the possible psychological or physical benefits from participation in the program.

Physician Name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_

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

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_