



Exceptional Equestrians of the Missouri Valley, Inc.

785 Yellow Finch Lane
Washington, MO 63090

**Therapeutic Riding Program
2019 Participant Application**

NAME: _____
STREET: _____
CITY: _____ COUNTY: _____ STATE: _____ ZIP: _____
DIAGNOSIS: _____ HOME PHONE: _____
BIRTH DATE: _____ GENDER: _____ HEIGHT: _____ in. WEIGHT _____ lbs.
EMAIL ADDRESS: _____

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

Parent _____ Phone #: _____ Alt. #: _____
Employer _____ Address: _____
Parent _____ Phone #: _____ Alt. #: _____
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):

Developmental Services of Franklin County Warren County Developmental Disabilities 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)

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

What are you looking to accomplish from Therapeutic Riding?

Exceptional Equestrians of the Missouri Valley, Inc.

785 Yellow Finch Lane, Washington, MO 63090
phone: 636-390-2141 fax: 636-239-7011

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.)
- _____ 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** _____



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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 _____

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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** _____



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 hereby 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:** _____