



EXCEPTIONAL EQUESTRIANS  
Spring Session #2 2012  
Rider Registration Form

April 2<sup>nd</sup>- May 26<sup>th</sup>

\*\* Please see attached calendar for specific session dates

REGISTRATION FORM MUST BE RETURNED BY March 16th

Classes will be scheduled on a first come, first served basis- Forms returned after March 16th may not fit into the schedule

NAME: \_\_\_\_\_  
Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)  
Phones: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Email: \_\_\_\_\_  
Disability: Primary Diagnosis: \_\_\_\_\_ Secondary Diagnosis: \_\_\_\_\_  
Parent or Guardian Name: \_\_\_\_\_  
Parent/Guardian Phones: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Please indicate your riding time preference below:

For example: Monday

Available Times: Anytime after 3:00 pm

Preference: 2<sup>nd</sup> choice

Tuesday

Available Times: Between 1-3

Preference: 1<sup>st</sup> Choice

Monday

Available Times: \_\_\_\_\_

Preference: \_\_\_\_\_

Tuesday

Available Times: \_\_\_\_\_

Preference: \_\_\_\_\_

Wednesday

Available Times: \_\_\_\_\_

Preference: \_\_\_\_\_

Thursday

Available Times: \_\_\_\_\_

Preference: \_\_\_\_\_

Friday

Available Times: \_\_\_\_\_

Preference: \_\_\_\_\_

Saturday

Available Times: \_\_\_\_\_

Preference: \_\_\_\_\_

My class preference is: \_\_\_Group (1 hour) \_\_\_Private (1/2 Hour) \_\_\_Vaulting\*\*  
(\*\*Vaulting is limited due to horse usage and suitability. Riders will only be placed in vaulting lessons if instructors deem appropriate.)

Fees: \$224 a session (8 weeks @ \$28/lesson)

\*\* Please note, we always willing to accept payment on whatever schedule works best for you. However, due to the service charges associated with frequent deposits, the cost if you pay weekly will be \$30 per lesson.

Please check here if you require a financial assistance application \_\_\_\_\_

What are your goals? (Use back of page if needed)

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

Please Return Form To: **Exceptional Equestrians**  
**PO Box 1384**  
**Washington, MO 63090**

\*\*Please do not hesitate to call (636) 390-2141 with any questions or concerns

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Rider Application  
2011-2012 Season

PLEASE PRINT LEGIBLY:

NAME: \_\_\_\_\_  
STREET: \_\_\_\_\_  
CITY: \_\_\_\_\_ COUNTY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
DISABILITY: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
BIRTH DATE: \_\_\_\_\_ GENDER: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ in. WEIGHT \_\_\_\_\_ lbs.  
EMAIL ADDRESS: \_\_\_\_\_

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

Father \_\_\_\_\_ Phone #: (home) \_\_\_\_\_  
Employer \_\_\_\_\_ (work) \_\_\_\_\_  
Mother \_\_\_\_\_ Phone #: (home) \_\_\_\_\_  
Employer \_\_\_\_\_ (work) \_\_\_\_\_  
Mother \_\_\_\_\_ Father – address if different from above:

\_\_\_\_\_  
(street) (City) (State) (zip)

Name and Address of **Legal Guardian** (if different from parent)  
\_\_\_\_\_  
\_\_\_\_\_  
(home) \_\_\_\_\_  
(work) \_\_\_\_\_

Name and Address of **Caregiver** (if different from parent)  
\_\_\_\_\_  
\_\_\_\_\_  
(home) \_\_\_\_\_  
(work) \_\_\_\_\_

**Rider Profile**

Rider has previously ridden with Exceptional Equestrians? \_\_\_ Yes \_\_\_ No—if yes, how many sessions?  
\_\_\_\_\_

Rider has previously ridden with another therapeutic riding program? \_\_\_ Yes \_\_\_ No— If yes, how many long? \_\_\_\_\_

Rider is: Ambulatory Non- ambulatory Verbal Non- verbal

Rider uses: Wheelchair Crutches Braces Walker Cane

Rider is able to sit independently: Yes No

\_\_\_\_\_  
Signature- adult rider or parent/guardian of minor rider Date

**Please Return Completed Form to**

Exceptional Equestrians, P.O. Box 1384, Washington, MO 63090 (636) 390-2141

## Exceptional Equestrians of the Missouri Valley, Inc.

PO Box 1384 Washington, MO 63090 phone- 636-390-  
2141

### AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I understand that no rider can be accepted for therapeutic riding instruction until this form has been completed by the parent(s) or guardian. If the rider is of legal age (18), he/she may complete the form, if he/she is legally competent to do so.

Name of rider \_\_\_\_\_ Date of

Birth \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Z

ip \_\_\_\_\_

Name of

mother/guardian \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_

Name of

father/guardian \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_

Guardian

address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

—

Name of

Physician \_\_\_\_\_ Phone \_\_\_\_\_

—

Physician

address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

—

Preferred Medical

Facility \_\_\_\_\_ Phone \_\_\_\_\_

Facility

address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

—

Health Insurance Co \_\_\_\_\_ Policy

# \_\_\_\_\_

**CONSENT PLAN:**

Consent

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**NON-CONSENT PLAN:**

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I do not give my consent for emergency medical treatment/aid for the rider 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 note that non-consent provisions are subject to review by the Exceptional Equestrians of the Missouri Valley, Inc. Board of Directors and may result in rider non-acceptance to the program).

Non-Consent

signature: \_\_\_\_\_ Date \_\_\_\_\_

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**ONSENT FOR RELEASE OF INFORMATION:**

I hereby authorize \_\_\_\_\_ (facility, individual, physician, etc.) to release information from the records of \_\_\_\_\_ (rider's name) to Exceptional Equestrians of the Missouri Valley, Inc. for the purpose of developing a Therapeutic Riding Program for the above-named rider. 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 \_\_\_\_\_

-

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

PO Box 1384 Washington, MO 63090 phone 636-390-2141

**STUDENT CONSENT, RELEASE AND INDEMNIFICATION AGREEMENT**

I/we, the parent(s) / guardian(s)\*\* of \_\_\_\_\_ (rider'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 Meramec 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.

**\*\*Initials**\_\_\_\_\_

**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 rider 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.

**\*\*Initials**\_\_\_\_\_

**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. or the North American Riding for the Handicapped Association 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    \*\*Initials\_\_\_\_\_**

Only initial here if you do NOT want your client's photo taken    NON- CONSENT

**\*\*Initials\_\_\_\_\_**

**PHYSICIAN RELEASE AND INDEMNIFICATION AGREEMENT**

I /We, the parent(s) / guardian(s)\* of \_\_\_\_\_(name of rider),  
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.

**\*\*Initials\_\_\_\_\_**

>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.

\*\*Please initial each section of this document to verify that your have read that section.

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

Rider Signature

\_\_\_\_\_ Date \_\_\_\_\_

—

Mother / guardian

Signature \_\_\_\_\_ Date \_\_\_\_\_

Father / guardian

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Exceptional Equestrians of the Missouri Valley, Inc.**  
**P.O. Box 1384, 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 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: \_\_\_\_\_