Unbridled Change
Therapeutic Riding Application Packet

Child's Name ____

Parent/Legal Guardian Name____

Address ____

City_______________________________________ State______ Zip________________

Home Phone__________________ Work Phone _______________________Ext________

Cell Phone #________________________________Pager #__________________________

Address____

Child's Date of Birth__________________________ Gender [ ] Male [ ] Female

School____

RIDERS UP! PROGRAM (PLEACE CHECK THE BOX FOR THE SESSION TIME YOUR SIGNING UP FOR)				
		Riders UP! Therapeutic Riding Lesson Blocks	**Private**	**Semi-Private**
☐		6 Week Session Wednesdays	$210.00	$150.00
☐		6 Week Session Saturdays	$210.00	$150.00
☐		6 Week Session Other day ____________________ *(We will try to accommodate other riding times based on volunteer and horse availability)*_____________	$210.00	

Make checks payable to ***Unbridled Change*** and attach to the completed application.
To pay by Visa or MasterCard please call our office at 540-719-2171.

If classes are full at the time this application is received your check will be returned and your child will be pleased on a waiting list.

PHOTO RELEASE
I consent to and authorize the use and reproduction by Unbridled Change of any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional material, educational activities, exhibitions of for any other use for the benefit of the organization.

Client's Signature: ____DATE_________________
Parent/Guardian & Title:____DATE_________________

Horse Sense of the Carolinas, Inc. Copyright 2007 All rights reserved

Current Medical Status

Client: ______________________________________ Age: ______
Street: ____________________________ City: _____________ State: ____ Zip: __________
Parents/Guardian/Spouse: _________________________________ Phone: _______________
Diagnosis: ____ Date of Onset: ________

For Persons with Downs Syndrome:

☐ Negative Cervical X-ray for Atlantoaxial Instability. X-ray date: _______________
☐ Negative for clinical symptoms of Atlantoaxial Instability.

Tetanus Shot: ☐ Yes ☐ No Date: ___________ Height: _______ Weight: __________
Seizure Type: __________________ Controlled: ____________ Date of last seizure: __________
Medications: ____
Indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility- Independent Ambulation: ☐ Yes ☐ No Crutches: ☐ Yes ☐ No Braces: ☐ Yes ☐ No
Wheelchair: ☐ Yes ☐ No Please indicate any special precautions: _________________
____
____

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. *PT, OT, Speech,* Psychologist ate.) in the implementing of an effective equestrian program.

Physician Name (please print): ____
Physician Signature: ____
Address: ____________________________ City: ___________ State: __ Zip: _________
Phone: (_____)_________________________ Date: _________________

Horse Sense of the Carolinas, Inc. Copyright 2007 All rights reserved

Unbridled Change
Therapeutic Riding Application Packet

Medical History, Emergency Information, & Health Care Consent (page 1 of 2)

Child's Full Name:____ Date of Birth:________

Street Address,____

City, State, Zip:____

Phone(s): H:______________________ W:_______________________ C:___________________

Height:_____________ Weight:______________ Tetanus Shot: Y[ ] N[ ]

Medications & Dosage	Taken Since	Prescribed by (Physician)

Please check any areas of medical concern. If "yes," please explain in the Comments section

Areas	Yes	No	Comments
Auditory	☐	☐	________________________
Visual	☐	☐	________________________
Speech	☐	☐	________________________
Cardiac	☐	☐	________________________
Circulatory	☐	☐	________________________
Pulmonary	☐	☐	________________________
Neurological	☐	☐	________________________
Muscular	☐	☐	________________________
Orthopedic	☐	☐	________________________
Allergies/Asthma	☐	☐	________________________
Learning Disability	☐	☐	________________________
Psychological Impairment	☐	☐	________________________
Diabetes	☐	☐	________________________
Other ____________	☐	☐	________________________

By signing this form, I, ________________________________ (please print parent/guardian name) certify all information to be complete and true to the best of my knowledge.

Parent/Guardian's Signature :___________________________________ Date:___________

Horse Sense of the Carolinas, Inc. Copyright 2007 All rights reserved

Medical History, Emergency Information, & Health Care Consent (page 2 0f 2)

Parent/Guardian________________________________Phone Numbers _________________

*1st Emergency Contact___________________ Relationship _______________ Phone _____________

*2nd Emergency Contact__________________ Relationship _______________ Phone _____________

*(*client's or parent/guardian's first choice for us to call if parent/guardian is unavailable in a medical emergency)*

Patient's Primary Physician____________________________ Phone Number______________________

Preferred Medical Facility: ____

Emergency Medical <u>Consent</u>

The undersigned hereby grants to any *Unbridled Change* affiliate/employee/intern/volunteer the authority to receive information pertaining to the emergency health care of the client named below and to make emergency health care decisions with respect to the child if the undersigned is unavailable to obtain such information or make such decisions.

Child's Name____ Phone:_____________________

Address:____

Date:___________________ Signature:____
(parent, guardian)

+++

Emergency Medical <u>Non-Consent</u>

If the undersigned <u>does not</u> desire to grant any *Unbridled Change* affiliate/employee/intern/volunteer information or to make health care decisions for the client if the undersigned is unavailable, please initial on the line below and state the procedures to be followed if the client becomes ill or is involved in an accident and the undersigned is unavailable.

____ I Do Not Consent to any *Unbridled Change* affiliate/employee/intern/volunteer obtaining health care information or making emergency health care decisions concerning the client.

Procedures to be followed:____

Date:___________________ Signature:____
(parent, guardian client)

Horse Sense of the Carolinas, Inc. Copyright 2007 All rights reserved

Confidentiality Agreement and Equine Activity Liability Release And Risk Acknowledgement (page 1 of 2)

Confidentiality Agreement

By signing below, I agree not to disclose any client names, treatment information or identifying information pertaining to any client, past, present or future, of *Unbridled Change* to anyone who is not affiliated with *Unbridled Change*. This confidentiality agreement is effective the date of the signing of this agreement, and is forever binding after my association with *Unbridled Change* ends.

Equine Liability Release and Risk Acknowledgement:

1. **Parties**. The parties to this document are *Unbridled Change* and ________________________ (hereinafter "client").
(print client name here)

2. **Apportionment of Liability**. In consideration of client being allowed to attend, participate in, or observe activities sponsored or conducted by *Unbridled Change*, or be present on the property on which *Unbridled Change* conducts its activities, client does agree to hold harmless and release *Unbridled Change*, its officers, members, managers, agents, employees, representatives, assigns, affiliated organizations, insurers, and all others acting on *Unbridled Change's* behalf and the owner(s) of any horse or other property used by *Unbridled Change*, from all claims, demands, causes of action, and legal liability, whether the same be known or unknown, anticipated or unanticipated even if due to negligence and/or other clients' acts or omissions. Client does further agree to waive all rights which may otherwise arise from an injury to client or client's property, and shall not bring any claims, demands, legal actions or causes of action, against *Unbridled Change*, those persons described above, or any person or entity, for any economic or non-economic losses due to bodily injury, death, or property damage arising out of the activities of *Unbridled Change* or client's presence on or proximity to property used by *Unbridled Change*.

3. **Indemnity**. Client agrees to be responsible for any and all damages, injuries, or loss of life caused by client or a horse in the care, custody and control of client, and to indemnify *Unbridled Change* and all parties described above, for any losses or expenses (including attorney fees) which they incur in connection with claims related to client.

4. **Risks**. According to the North American Horseman's Association, numerous obvious and non-obvious inherent risks are always present in horseback riding and being around horses, despite all safety precautions. No horse is a completely safe horse. Horses are 5 to 15 times larger, 20 to 40 times more powerful and 3 to 4 times faster than a human. If a client falls from a horse to the ground it will generally be at a distance of 3 to 5 feet, and the impact may result in injury to the client. If a horse is frightened or provoked it may divert from its training and act according to its natural instincts which may include, but are not limited to: stopping short, changing direction or speed at will, shifting its weight from side to side, bucking, rearing, biting, kicking or running from danger. These risks exist for any person around a horse, whether mounted or on the ground. Client acknowledges these risks and states that she/he is not relying on *Unbridled Change* to advise of all the risks.

Horse Sense of the Carolinas, Inc. Copyright 2007 All rights reserved

5. **Acknowledgment and Assumption of Risks**. Client acknowledges that she/he bears responsibility for her/his own safety and client should not participate in any client activity unless she/he is confident that she/he can do so safely. Participation in equine activities with or conducted by *Unbridled Change* constitutes a knowing and voluntary assumption of all risks associated with equine activities involving *Unbridled Change* or being present on or using *Unbridled Change* property (including but not limited to inherent risks and the risk of negligence by *Unbridled Change* or others) which is a defense under Virginia law to any claim for injury or damage, and a bar to recovery.

6. **Helmet Use.** Client acknowledges that wearing a properly fitted and secured client riding helmet which meets or exceeds the quality standards of the SEI Certified ASTM Standard F1163 while riding, mounting, dismounting and being near horses **may** reduce the severity of head injuries or prevent death occurring as the result of a fall or other occurrence. *Unbridled Change* makes no representations as to the condition, effectiveness or suitability of any helmet it may allow client to use. All helmet related risks are assumed by client.

7. **Visitors**. Should client bring to *Unbridled Change* any person who is not a party to an Equine Activity Liability Agreement with *Unbridled Change*, client agrees to educate them as to the risks of being around horses and horse operations, supervise them, be solely responsible for their safety, and to be financially responsible for any injury or loss caused by or suffered by any such person.

8. **Safety Rules.** Client agrees to follow such rules for safety as are attached or are subsequently provided to them, or posted. Client acknowledges that failure to follow *Unbridled Change* safety rules or the directions of *Unbridled Change* 's staff may put her/him at risk of, or increase the risk of, personal injury.

9. **Premises Inspection.** Client has inspected the farm's premises and facilities and/or have in some other way satisfied himself/herself that the condition of the premises and the facilities will provide an adequate and reasonable level of safety for client and any guests, or visitors they bring on the premises.

10. **Other Terms.** This document states the entire agreement between the parties as to liability and may not be changed, except in writing signed by the parties. The benefits of this agreement, including the release of legal liability, waiver of rights, indemnity and covenant not to sue, are intended to benefit others, including *Unbridled Change's* officers, directors, members, managers, agents, employees, representatives, assigns, affiliated organizations, insurers, and all others acting on *Unbridled Change's* behalf and the owner(s) of any horse or other property used by *Unbridled Change*. This agreement shall be binding upon *Unbridled Change*, client, and client's heirs or estate, when signed by the parties. If any clause, phrase or work is in conflict with State Law then that single part is null and void. This agreement and acknowledgments shall remain in force until terminated by client through written notice to *Unbridled Change* at the address above. The General Court of Justice Franklin County, Virginia shall be the exclusive venue for any litigation between client and the parties described above.

____ ________________

Signature of Child's Parent/Guardian Date

Horse Sense of the Carolinas, Inc. Copyright 2007 All rights reserved