Kassie Schuerr—Director
Equine Assisted Therapeutic Riding Facility
4390 N. Glen Rd. Kingman, Az. 86409 928-279-7581
www.kingmanshealinghooves.com

Therapeutic Rider Information

General Information:

Name:_____Date_____

Address_____

City/State/ZIP:_____ Date Of Birth:_____

Employer or student/school_____

Phone: (H)_____(W)_____(C)_____

Parent/Legal Guardian_____(C)_____

Address if different:_____

Email (self or parent/guardian):_____

HEALTH HISTORY:

Last Tetanus shot:_____TB (+-)_____Date:_____
(You are welcome to help without an updated shot, although keep in mind that Tetanus is caused by the bacterium *Clostridium tetanii* which can be found in soil and droppings just about everywhere. It survives in the environment for long periods of time)

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Address fitness, cardiac, respiratory, bone and joint function, recent hospitalizations/surgeries and lifestyle changes. A Dr. Release form will be required on all riders with severe back pain, Severe muscle atrophy, fragile bones, paraplegic and quadriplegic riders.: Safety is our number one concern and we need to make sure riding horses won't damage or make conditions worse.

_____
_____
_____

ALLERGIES:

_____
_____
_____

MEDICATIONS:

_____
_____
_____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Riders Name:_____Date_____

Address_____

City/State/ZIP:_____ Date Of Birth:_____

Employer or student/school_____

Phone: (H)_____(W)_____(C)_____

In the event of an emergency, please contact:
NAME_____Relationship_____phone_____
NAME_____Relationship_____phone_____

Primary Physician _____Phone_____
Preferred Facility _____Heath Ins._____
Policy #_____

In the event of an emergency, medical aid/treatment is required due to illness or injury during the process of receiving services, or while on the property; I authorize (**ASTHTARL) and (KHHEATRC)** and its agents to:

1. Secure and retain medical treatment and transportation if needed; and
2. Release client records upon requests to the authorized medical individual or agency involved in treatment.

CONSENT PLAN—This authorization includes, but is not limited to; x-ray, surgery, hospitalization, medication, and any treatment deemed "lifesaving" by the physician. This provision will be invoked only if above person(s) is unable to be reached.

CONSENTING SINGNATURE _____DATE_____

NON-CONSENT PLAN—I do not give my consent for emergency medical treatment or aid in the event of illness or injury on the property of (**ASTHTARL) and (KHHEATRC).** Parent or Legal Guardian will remain on site all times during equine assisted activities. In the event emergency treatment/aid is required, I authorize the following procedures to take place:_____
_____

SIGNATURE_____DATE_____

Rider Photo/Video Release Form:

PHOTO/VIDEO Release ( ) I do ( ) I do NOT
Consent to and authorize the use and reproduction by (**ASTHTARL) and (KHHEATRC)** of any and all photographs and any other audio, visual materials taken of me for promotional material, education activities, exhibitions, or for any other use for the benefit of the center.

SIGNATURE_____DATE_____

LIABILITY:
I hereby acknowledge there are risks and potential risks inherent to horseback riding. I believe by participating in Therapeutic Riding, the benefits to my health are greater than risks assumed. I have seen and read the warning signs posted on the front gates regarding the dangers of horse back riding.

I herby intend to be legally bound for myself, my heirs and assigns, executors or administrators. In addition, I waive and release forever all claims and damages against (**ASTHTARL) and (KHHEATRC),** it's owner, Board Of Directors, employees, volunteers, and contractors. I accept the risk and assume the responsibility for any and all injuries and/or losses I may sustain while participating in equestrian activities or while on the premises of (**ASTHTARL) and (KHHEATRC).**

Participant_____ Date_____
(Print name)

Signature_____
(Participant, Parent/Legal Guardian)

How did you hear about our facility? _____