

**Therapeutic Equestrian Center, Inc.
537 Northampton Street
Holyoke, MA 01040**

Rider's Registration and Release Form

Registration

Client: _____

Date of Birth: _____ Age: _____

Street: _____

City _____ State: _____ Zip Code: _____

Home Phone: _____ Alternate Phone: _____

Parent or Guardian: _____

Address: _____

Phone: _____

School/Institute: _____

In Case of Emergency Contact: _____

Phone: _____

Contact: _____

Phone: _____

Liability Release

_____ (Client's Name) would like to participate in the Therapeutic Equestrian Center's riding program. I acknowledge the risks and potential for risks involved in horseback riding. However, I feel that the possible benefits to myself/my child/or my ward or guardian are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against the Therapeutic Equestrian Center in Holyoke, including its Board of Directors, Instructors, therapists, Aides, Volunteers and Employees for any and all injuries and or losses sustained while participating in Therapeutic Equestrian Center's Riding program.

Date: _____

Signature: _____

(Client, Parent or Guardian)

Photo Release (Optional)

I hereby consent to and authorize the use and reproduction by The Therapeutic Equestrian Center of any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Date: _____

Signature: _____

(Client, Parent or Guardian)

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Riders Consent for Release of Information

I hereby authorize

(Person or Facility)

To release information from the records of:

(Client's Name)

The information is to be released to the Therapeutic Equestrian Center in Holyoke, MA for the purpose of developing a Therapeutic Riding Program for the above named student. The information to be released is marked below.

- 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: _____

Date: _____

Signature: _____
(Client, Parent or Guardian)

Please send the indicated materials to:

**Therapeutic Equestrian Center, Inc.
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Rider's Authorization for Emergency Medical Treatment Form

In the event emergency medical aid/treatment is required due to illness or injury during this process of receiving services, or while being on the property of the agency, I authorize The Therapeutic Equestrian Center in Holyoke, MA to:

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

Clients Name: _____

Phone: _____

Address: _____

In the event I cannot be reached,

Contact: _____ Phone: _____

Contact: _____ Phone: _____

Physician's Name: _____

Phone: _____

Health Insurance: _____

Policy #: _____

Preferred Medical Facility: _____

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Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Date: _____

Non-Consent Signature: _____

Print Name: _____

Phone: _____

Address: _____

Non Consent Plan

I do not give my consent for emergency medical treatment/aid 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:

Date: _____

Non-Consent Signature: _____

Print Name: _____

Phone: _____

Address: _____

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PHYSICIAN'S REFERRAL

To be filled out by the student's physician

Dear Sir or Madam:

This referral is part of an application for this patient to participate in a therapeutic riding program at the Therapeutic Equestrian Center (T.E.C.) in Holyoke, MA. T.E.C. offers horseback riding as a method to improve self image, self control, cognitive sequencing, muscle strength, balance reactions, and the ability to enjoy and succeed at an athletic activity involving animals. Each riders' program is planned individually and takes into account the student's medications, physical abilities, and disabilities. Please fill out this referral as completely as possible indicating as many details, especially aspects that you think would have behavioral or physical effects in relationship to horseback riding.

Thank you!

PATIENT NAME: _____

DATE OF BIRTH: _____ HEIGHT _____ WEIGHT _____

DIAGNOSIS** : _____

DATE OF ONSET: _____

BRIEF MEDICAL HISTORY:

SURGICAL PROCEDURES:

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PHYSICIAN REFERRAL (Continued)

PATIENT NAME: _____

MEDICATIONS:

SIDEEFFECTS:

****All Down's syndrome patients must be x-rayed for Atlantoaxial dislocation.****

Please comment where applicable:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Neuro-sensation | <input type="checkbox"/> Muscle tone |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Coordination | <input type="checkbox"/> Circulation |
| <input type="checkbox"/> Speech | <input type="checkbox"/> Balance | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Assistive devices | <input type="checkbox"/> Allergies | <input type="checkbox"/> Incontinence |

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PHYSICIAN REFERRAL (Continued)

PATIENT NAME: _____

Precautions pertaining to horseback riding:

In my opinion, this patient can receive riding instruction under appropriate supervision. In conjunction with the riding program, I concur in the referral of this patient to the staff physical therapist for evaluation of his/her abilities and/or limitations in performing exercises.

Physician's name

Physician's signature

Address

Date

Phone number

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PHYSICIAN'S REFERRAL (CONTINUED)

PATIENT NAME: _____

For the safety of our riders, T.E.C. requires that all **Downs' Syndrome** applicants request their physician to complete this form.

This certifies that _____ has received a medical examinations and lateral view roentgenograms of the upper cervical region in full flexion and extension.

Date of Examination: _____

Name of Physician: _____

____ This examination **did not** reveal atlantoaxial instability or neurologic disorder.

____ This examination **did** reveal atlantoaxial instability or neurologic disorder.

Physician's signature

Date signed

Physician's Address:

Phone Number:

The Therapeutic Equestrian Center

The Therapeutic Equestrian Center (TEC) is a non-profit organization that relies on many state and federally funded programs and grants. In order for TEC to apply for these funds it is necessary for us to request the following information. This information will be kept strictly confidential. If this information is incomplete, we are unable to process your application.

1. Total number of people in household _____

2. Female Head of Household: Yes No
(circle one)

3. Race: *Please Check One*

White

Black

Asian

American Indian

Pacific Islander

Multi-Racial

4. Hispanic: Yes No
(circle one)

5. Total Household Yearly Income: *Please Check One*

Below \$10,000

\$10,001 to \$15,000

\$15,001 to \$20,000

\$20,001 to \$30,000

\$30,001 to \$40,000

\$40,001 to \$50,000

\$50,001 to \$60,000

\$60,001 to \$70,000

\$70,001 to \$80,000

\$80,001 to \$90,000

\$90,001 to \$100,000

Over \$100,000