Lenawee Therapeutic Riding

Rider Registration and Emergency Treatment Form

This form is valid for a period of one year from the date signed.

No individual can be accepted for riding instruction in a Michigan 4-H Proud Equestrians Program until this form has been completed by his/her parent(s)/guardian or by the individual if he/she is a legally competent adult 18 years of age or over.

Date_____ ❑ New Rider ❑ Return Rider School Attending _____

Rider: Full Name _____ Date of Birth_____
Mailing Address_____
City _____ State _____ Zip_____
Phone (_____)_____
Diagnosis_____ Date of Onset _____
Age_____ Height _____ Weight _____
Previous Riding Experience _____

Parent/Guardian: Full Name:_____ Phone (_____)_____
Mailing Address_____
City _____ State _____ Zip_____

Physician: Name _____ Phone (_____)_____
Address _____
City _____ State _____ Zip_____

Person who should be notified in case of emergency in absence of parent/guardian:
Name_____ Phone (_____)_____
Relationship to Rider_____

AUTHORIZATION FOR PURPOSE OF PROVIDING MEDICAL TREATMENT

You are being asked to complete this form to give an appropriate medical facility permission to treat _____ _____(rider's name) for minor injury or medical problems. In the event of serious injury or illness, you will be contacted; treatment will proceed before contacting you only if the situation is urgent and does not permit delay.

Preferred Medical Facility _____

Is there a medical condition, allergy, etc., requiring special precaution or treatment? ❑ Yes ❑ No
If Yes, please describe:_____

Medications currently being used? ❑ Yes ❑ No If Yes, please list name, purpose and dosage: _____
_____

In case of medical emergency: The undersigned authorizes the Michigan 4-H Proud Equestrians Program instructor and/or program coordinator to seek any medical and/or surgical treatment necessary for the care of _____ who is participating in the Michigan 4-H Proud Equestrians Program with parent/guardian permission and with the permission of his/her physician (name)_____.

HEALTH INSURANCE

Name of Policyholder/Relationship to Participant:_____
Policyholder's address_____
Please attach a photocopy of both sides of your insurance card (preferred) OR complete the insurance information requested here.
Name and Address of Insurance Company_____
Insurance Company Phone Number (_____)_____ **Policy Number**_____
Name of Policyholder's Employer_____

REQUIRED SIGNATURES

The above designated person(s) is(are) hereby authorized to incur medical costs necessary to provide medical treatment for said participant for which we shall be fully responsible. We also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Signature: _____ **Date:**_____
Parent(s) / Guardian / Adult Rider (Circle appropriate title)

Witness:_____

Michigan 4-H Proud Equestrians Program Parent/Guardian-Adult Rider Informed Consent and Release of Liability Agreement

This form is valid for a period of one year from the date signed.

No individual can be accepted for riding instruction in the Michigan 4-H Proud Equestrians Program until this form has been completed by his/her parent(s)/guardian or by the individual if he/she is a legally competent adult age 18 or older.

I/we assume the risks and accept the consequences involved in the participation of:

_____,
Rider's Name

in the Michigan 4-H Proud Equestrians Program,

_____,
Program Name

_____
County

I/we acknowledge that horses may be dangerous because they may, without warning, buck, stumble, kick, or move in otherwise unpredictable ways.

I/we are hereby informed of the possible dangers to me/my child/my ward that may result from participation in the program, including soft tissue (including skin and muscle) injury, ligament and tendon injury, bone/joint injury, and exacerbation of chronic conditions.

I/we accept the responsibility for complying fully with all safety rules and practices and I/we will consult with the instructor and/or local director of the Michigan 4-H Proud Equestrians Program for advice in circumstances where safe practices are in doubt.

I/we hereby release Michigan State University and Michigan 4-H Proud Equestrians Program, including their instructors, staff and volunteers, from any liability for injury that may result from participation in the program. This release does not encompass "gross negligence."

I/WE HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Signature: _____ **Date:** _____
Parent(s) / Guardian / Adult Rider (circle appropriate title)

Witness: _____ **Time:** _____

Michigan 4-H Proud Equestrians Program Parent/Guardian-Adult Rider Video, Film and Photography Release Form

This form is valid for a period of one year from the date signed.

No individual can be accepted for riding instruction in a Michigan 4-H Proud Equestrians Program until this form has been completed by the rider's parent(s)/guardian or by an adult rider who is a legaly competent adult 18 years of age or over.

Note: Participation in a Michigan 4-H Proud Equestrians Program as a rider is **not** contingent on an affirmative (yes) response on this "Parent/Guardian-Adult Rider Video, Film and Photography Release Form."

I authorize Michigan State University to record the image and voice of the subject named below and give MSU and all persons or entities acting pursuant to MSU's permission or authority, all rights to use of these recorded images and voice. I understand that said images and/or voice will be used for educational, advertising and promotional purposes in all conventional and electronic media, including but not limited to the Internet, and any future media. I also authorize the use of any printed material in connection therewith. I understand and agree that these images and recordings may be duplicated, distributed with or without charge, and/or altered in any form or manner without future or further compensation or liability, in perpetuity.

❑ Yes ❑ No

Full Name of Subject: _____
(Child's name, or legally competent adult rider over the age of 18.)

Parent/Guardian (if subject is under 18 years old): _____
Parent/Guardian

Address: _____

_____

City: _____ State: _____ Zip: _____

Signature: _____ **Date:** _____
Parent/Guardian

Signature: _____ **Date:** _____
Adult rider over the age of 18

Lenawee Therapeutic Riding

Michigan 4-H Proud Equestrians Program
Physician's Referral for Horseback Riding

This form is valid for a period of one year from the date signed.

No individual can be accepted for riding instruction in a Michigan 4-H Proud Equestrians Program until this form has been completed by his/her physician.

Rider's Name:_____ **Date:**_____

Address: _____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____ Height:_____ Weight:_____

Parent/Guardian (if under 18):_____

The Michigan 4-H Proud Equestrians Program is a therapeutic horseback riding program designed to benefit the riders physically, socially, and emotionally. Only certified therapeutic riding instructors who meet the requirements for approval by Michigan 4-H Youth Development are qualified to teach in the program. Appropriate safety equipment is used at all times. Volunteers and horses are trained to meet the needs of the riders.

In order to ensure the riders' fullest possible protection and greatest personal benefit from the program, every rider is required to furnish the following medical information before being accepted as a riding student.

Diagnosis: _____

_____ Date of Onset:_____

If diagnosis is Down Syndrome, this form must be accompanied by one of the following documents:

1. Michigan 4-H Proud Equestrians Program Down Syndrome Rider Evaluation
2. A signed, dated statement from a qualified physician giving the date and result of a diagnostic x-ray for Atlanto-Axial Dislocation Condition

   NOTE: Because of the nature of the activity of horseback riding, no individual diagnosed as having Down Syndrome can be accepted for riding instruction without proof of a negative diagnostic x-ray for Atlanto-Axial Dislocation Condition.

Medical History:_____

_____

_____

Surgical Procedures:_____

_____

Medications: _____

For: _____

Defects Present In: ❑ Sight ❑ Hearing ❑ Speech ❑ Neuro-sensation ❑ Muscle Tone ❑ Balance ❑ Coordination ❑ Mobility

Are braces or other assistive devices used? ❑ Yes ❑ No

Specify: ❑ Crutches ❑ Wheelchair ❑ Walker ❑ Other_____

NOTE: Due to the nature of the activity, indwelling spinal rods are contraindicative to horseback riding.

Comment if Applicable: Seizures: _____

Incontinence: _____ Other:_____

General Comments: _____

_____

In my opinion, the patient named can receive riding instruction under appropriate supervision.

Physician's Signature:_____ **Date:**_____ **Phone:**(_____)_____

Address: _____

City:_____ **State:**_____ **Zip Code:**_____

Lenawee Therapeutic Riding

Michigan 4-H Proud Equestrians Program
Physical or Occupational Therapist and/or Teacher Assessment

This form is valid for a period of <u>one</u> year from the date signed.

Rider's Name:_____ Date:_____

Address: _____

City:_____ State:_____ Zip Code:_____

Age:_____ School or Group Affiliation:_____

Diagnosis: _____

The Michigan 4-H Proud Equestrians Program is a therapeutic horseback riding program designed to benefit the riders physically, socially, and emotionally. Only certified therapeutic riding instructors who meet the requirements for approval by Michigan 4-H Youth Development are qualified to teach in the program. Appropriate safety equipment is used at all times. Volunteers and horses are trained to meet the needs of the riders.

In order to ensure the fullest possible protection and greatest personal benefit for each rider, you are asked to furnish the following information, to be used in conjunction with the rider's Physician's Referral, in developing his/her individualized program. All information is maintained in confidentiality as prescribed by Public Laws 94-142.

❑ Rider not currently working with therapist or teacher (Parent/Guardian or Adult Rider please sign below)

Physical Limitations: _____

_____

_____

_____

_____

Precautions to be observed:

1. Mounting: _____
2. Riding:_____
3. Dismounting:_____

NOTE: Mounting blocks and ramps are available for use as needed.

Suggested Exercises:

1. Pre-ride: _____
2. Mounted:_____
3. Post-ride:_____

Social/Emotional Responses:

1. Attitude:_____
2. Communication: _____
3. Behavior:_____

Suggested areas to be improved through participation in the Michigan 4-H Proud Equestrians Program:

_____

_____

COMMENTS:_____

_____

_____

Signature:_____ or Signature:_____

Physical/Occupational Therapist/Teacher — Paren/Guardian/Adult Rider

Address:_____

City:_____ State:_____ Zip Code:_____

Lenawee Therapeutic Riding

Michigan 4-H Proud Equestrians Program
Down Syndrome Rider Evaluation

This form is valid for a period of one year from the date signed.
(To be signed and dated by parent/guardian and/or adult rider as well as examining physician)

Name: _____ Address: _____

_____

City:_____ State:_____ Zip Code: _____

There is increasing evidence from medical research that up to 10% of individuals with Down Syndrome suffer from a condition known as Atlanto-Axial Dislocation, which is a malalignment of cervical vertebrae C-1 and C-2 in the neck. This condition exposes Down Syndrome individuals to the possibility of injury if they participate in activities that hyperextend or radically flex the neck muscles. Due to the nature of the activity of horseback riding and sincere concern for the welfare of the students in the program, the Michigan 4-H Proud Equestrians Program is able to accept an individual with Down Syndrome for riding instruction only after he/she has been examined (including x-ray views of full extension and flexion of the neck) by a physician who understands the nature of the Atlanto-Axial Dislocation condition.

Parent/Guardian and/or Adult Rider Consent

I, the undersigned parent/guardian or adult rider, have read and understand the above message and do hereby consent to and authorize the physician's examination, or release of the results if the examination has already been performed, prior to the student's beginning riding instruction.

_____ Date:_____
Signature of Parent/Guardian and/or Adult Rider

Physician's Statement

On examination of the rider, whose name is noted at the top of this page, and upon review of the rider's cervical spine x-rays, including full flexion and full extension views, I find the rider has:

Check one: ❑ No evidence of Atlanto-Axial Dislocation
❑ Positive or equivocal evidence of Atlanto-Axial Dislocation

Physician's Signature:_____ Date: _____

Please Print:

Physician's Name:_____ Phone: (_____)_____

Address:_____

City:_____ State:_____ Zip Code: _____

This evaluation is not valid until the date and signature of the parent/guardian or adult rider and physician is affixed.