



# HORSES WITH H.E.A.R.T., INC. (Hands-on Equine Assisted Riding Therapy)

P.O. Box 2427, Chino Valley, AZ 86323  
Office: (928) 533-9178

Revised January, 2013

## RIDER REGISTRATION AND RELEASE FORM

*The HwH Mission: To provide a safe and enjoyable equine experience for people with physical, mental and emotional disabilities and encouraging each rider to develop independent skills at their own level of ability.*

### REGISTRATION -

Date Form Completed: \_\_\_\_\_

Rider's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Rider's Email Address: \_\_\_\_\_

Name and Phone Number of Other Contact (as necessary): \_\_\_\_\_

Parent(s)/Guardian(s): \_\_\_\_\_

Parent/Guardian's Email Address: \_\_\_\_\_

Mailing Address (if different than above): \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

School/Institution presently attending: \_\_\_\_\_ City: \_\_\_\_\_

### NON-DISCRIMINATION POLICY -

Horses with H.E.A.R.T., Inc. is committed to providing all participants (riders, volunteers, board members, contractors and staff) with an environment free from all types of harassment and discrimination based on race, color, religion, national origin, sexual orientation, age, gender, physical, emotional or intellectual disability or veteran status. Horses with H.E.A.R.T., Inc. prohibits and will not tolerate such harassment or discrimination by anyone affiliated with or those who do business with Horses with H.E.A.R.T., Inc.

It is our policy to maintain a positive environment free from all forms of harassment or discrimination and to insist that everyone be treated with dignity, respect and courtesy. The purpose of this policy is not to regulate our participants' personal morality. It is to assure that harassment or discrimination does not occur at our facility. All complaints of harassment or discrimination will be thoroughly, promptly and objectively investigate[]d.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Client, Parent/Guardian (required if 18 years of age or under)

### CONFIDENTIALITY STATEMENT -

Volunteers, riders and families have a right to privacy that gives them control over the dissemination of their medical and/or other sensitive information. Horses with H.E.A.R.T. shall preserve that right of confidentiality for all individuals in its program. I, by signing below, acknowledge this policy and will abide by it.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Client, Parent/Guardian (required if 18 years of age or under)

### PHOTO RELEASE -

I, hereby, consent to and authorize the use and reproduction by Horses with H.E.A.R.T., Inc., of any and all photographs and any other audio/visual materials taken of me/my child/my ward for promotional printed material, educational activities, exhibitions or any other use for the benefit of the program.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Client, Parent/Guardian (required if 18 years of age or under)

# RIDER APPLICATION



This information is confidential and will only be used by the Riding Instructor to better assist the client.

Date Form Completed: \_\_\_\_\_

Rider Name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Siblings: (Name(s) and Age(s)): \_\_\_\_\_

Disability (Primary and Secondary) \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Medication(s) \_\_\_\_\_

Seizure: Yes \_\_\_\_\_ No \_\_\_\_\_ Date of last Seizure \_\_\_\_\_ Controlled \_\_\_\_\_

Ambulation (Wheelchair, canes, etc): \_\_\_\_\_

Doctor's Name/Address/Phone: \_\_\_\_\_

Therapist's Name/Address/Phone: \_\_\_\_\_

**Please provide a copy of any current therapy reports to Horses with H.E.A.R.T., Inc.**

Is your therapist willing to interact with Horses with H.E.A.R.T., Inc. Yes \_\_\_\_\_ No \_\_\_\_\_

School/Education/Day Program: \_\_\_\_\_

Physical Limitation(s): \_\_\_\_\_

Effective Positive Reinforcements: \_\_\_\_\_

Attention Span: \_\_\_\_\_ Sitting Posture: \_\_\_\_\_

Visual: \_\_\_\_\_ Hearing: \_\_\_\_\_

Speech: \_\_\_\_\_ Prosthesis: \_\_\_\_\_

**Please answer the following questions if applicable (use extra sheets, if needed):**

1. Have there been any significant changes in the rider's condition within the past 3 to 6 months? \_\_\_\_\_

2. Please let us know of any changes in health or physical development. \_\_\_\_\_

3. How did you hear about Horses with H.E.A.R.T., Inc. \_\_\_\_\_

4. Is there anything we should know about the rider? \_\_\_\_\_

5. What are your expectations of Horses with H.E.A.R.T., Inc. \_\_\_\_\_

6. Please indicate any special billing information. \_\_\_\_\_

Additional comments (as needed): \_\_\_\_\_

**HwH reserves the right to limit participation in mounted activities when, in the professional opinion of HwH staff, risk to safety or well being of the participant, horse, or HwH facilitation team are identified.**



# HORSES WITH H.E.A.R.T -- AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize HORSES WITH H.E.A.R.T. 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.

Rider/Volunteer Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian/Emergency Contact Person: *(Person who is authorized to give temporary assistance/ care in absence of parent/guardian)*

1. Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

2. Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

3. Physician's Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Insurance ID \_\_\_\_\_

**ALLERGIES, MEDICAL CONDITIONS and MEDICATIONS**  
*(Please list any medical problems, special situations, seizure activity, etc.)*

\_\_\_\_\_

\_\_\_\_\_

### **CONSENT PLAN**

This authorization includes X-ray, surgery, hospitalization, medical and any treatment deemed "Life Saving" by the physician. This provision will only be invoked if the person listed below is unable to be reached.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_

*(Rider, Volunteer or Parent/Guardian if rider or volunteer is under the age of 18)*

PRINT Contact Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

### **NON-CONSENT PLAN**

I do not give my consent to 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: \_\_\_\_\_

*(Rider, Volunteer or Parent/Guardian if rider or volunteer is under the age of 18)*

PRINT Contact Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

**No person can be accepted for riding instruction until this form has been completed by the parent/guardian. If the person is of legal age (18), he/she may complete the form, if he/she is legally competent to do so. Riding instruction will be under strict supervision and although every effort will be made to avoid any accident, NO LIABILITY can be accepted by any of the organizations concerned, including Horses with H.E.A.R.T., Inc.**



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**MEDICAL HISTORY/PHYSICIAN RELEASE**

Name: \_\_\_\_\_ DOB : \_\_\_\_\_ Age: \_\_\_\_\_

Sex: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Cause: \_\_\_\_\_

Seizure Type (if any): \_\_\_\_\_ Controlled: \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

Medications (Type, Purpose and dose): \_\_\_\_\_

Tetanus Shot: Yes No Date: \_\_\_\_\_

**Persons with Down Syndrome: This section must be completed in order to participate.**  
 Cervical X-Ray for Atlantoaxial Instability: Positive: \_\_\_\_\_ Negative: \_\_\_\_\_ X-Ray Date: \_\_\_\_\_

Please indicate if the client has, or had a history of, the following secondary problems, by checking yes or no. If Yes, please include COMPLETE information pertaining to the problem.

PROBLEM	Yes	No	IF YES, DESCRIBE
Auditory Impairment			
Visual Impairment			Glasses?
Speech Impairment			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Cardiac			
Pulmonary/COPD			
Neurological			
Muscular			
Orthopedic (Skeletal) / Scoliosis Degree			
Balance			
Allergies (Please Include Medications)			
Asthma			
Shunts			
Postural Hypertension			
Hemophilia			
Orthotics			
Other			

**Mobility:** Independent Ambulation: Yes No **Crutches:** Yes No **Braces:** Yes No **Wheelchair:** Yes No

Please indicate any special precautions: \_\_\_\_\_

In my opinion this patient can participate in supervised equestrian activities. In conjunction with these activities, I concur in the referral of the patient to a physical/occupational therapist or other health care professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program.

Physician's Name (PLEASE PRINT): \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/State/ZIP: \_\_\_\_\_ Phone: \_\_\_\_\_

**THIS FORM IS VALID FOR A PERIOD OF 2 YEARS FROM THE DATE SIGNED. IT MUST HAVE AN ORIGINAL SIGNATURE. A NEW MEDICAL RELEASE MAY BE REQUESTED AT ANY TIME IF NOTICEABLE CHANGES HAVE BEEN OBSERVED BY HWH STAFF MEMBER AND/OR REPORTED BY PARENT OR GUARDIAN.**

**PLEASE RETURN TO: Horses with H.E.A.R.T., P.O. Box 2427, Chino Valley, AZ 86323 Phone: 928-533-9178**



RIDER/VOLUNTEER NAME: (Please Print) \_\_\_\_\_

PHONE NUMBER: (AREA CODE) (\_\_\_\_\_) \_\_\_\_\_

### HORSES WITH H.E.A.R.T. LIABILITY RELEASE

I understand that horses are unpredictable and even the most docile animal can and may step on, bite, push off balance, stumble, throw, or otherwise injure any person working with or around it. I will exercise safety precautions for my own protection, and I agree to abide by the policies and procedures of Horses with H.E.A.R.T., as such policies may be amended from time to time. I also agree to exercise proper care and conduct at all times while on or near any horse.

Neither Horses with H.E.A.R.T., nor any of its officers, instructors, volunteers, participants, employees, agents or owners of the property where Horses with H.E.A.R.T. events are conducted shall be held liable for any claims, demands, injuries, or damages, arising out of or in connection with my participation in any Horses with H.E.A.R.T. event.

I further acknowledge that I will not hold Horses with H.E.A.R.T., its officers, instructors, volunteers, participants, employees, agents or owners of the property where Horses with H.E.A.R.T. events are conducted, liable or responsible for any injury sustained by me while participating in activities at sites where horse therapy classes and related events may be held. I ride and/or participate at my own risk, and agree to take all necessary precautions to prevent any and all accidents. These precautions include, but are not limited to, the wearing of protective headgear.

I hereby release Horses with H.E.A.R.T., its officers, instructors, volunteers, participants, employees, agents as well as the owner of the property, where lessons, horse shows or other Horses with H.E.A.R.T. events occur, from all liability for property damage and personal injury to me, and I assume the risk of injury which I may sustain arising from approaching, handling, or riding a horse in connection with Horses with H.E.A.R.T. activities.

This agreement shall apply to any horse or horses being used or maintained upon the grounds where a Horses with H.E.A.R.T. event is being held, or any person or equipment affiliated with said event.

Furthermore, I assume full responsibility and liability for the conduct and safety of any and all persons I bring onto the property where Horses with H.E.A.R.T. events are conducted, including minors.

<p><b><u>VOLUNTEERS:</u></b> I represent that I am physically able to undertake all reasonable volunteers' activities and I participate in such activities at my own risk. INITIALS: _____  <b>Jr. Vol. Parent/Guardian</b> (required if under 18 years of age) INITIALS: _____</p> <p><b><u>RIDERS:</u></b> I represent that I am physically able to undertake riding activities and equine interaction and I do so at my own risk. INITIALS: _____  <b>Rider or Parent /Guardian</b> (required if under 18 years of age) INITIALS: _____</p>
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WARNING: Under Arizona law, a sponsor or equine professional is not liable for any injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to A.R. S. s12-553.

I have read and understand all of the above and waive any claim which may arise against Horses with H.E.A.R.T., its officers, instructors, volunteers, participants, employees, agents or owners of the property where Horses with H.E.A.R.T. events are conducted.

This agreement is effective upon signing and continues so long as I participate in Horses with H.E.A.R.T. events. I agree to pay all costs and attorneys' fees arising from any suit, legal proceedings or threatened proceedings that are or may be brought by me contrary to the terms of this Agreement.

\_\_\_\_\_  
**Signature of Rider or Volunteer**

\_\_\_\_\_  
**Signature of Parent/Guardian** (required if 18 years of age or under)

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

*Return to: Horses with H.E.A.R.T., Inc., P.O. Box 2427, Chino Valley, AZ 86323 (928) 533-9178*