EQUINE RECREATION REGISTRATION AND RELEASE FORM

DATE: __________RIDER'S NAME: _____________________________________ DOB: ____________
STREET: ________________________________CITY:_________________________ZIP: _____________
COUNTY: _________HOME PHONE: (______) _____________Gender____
PARENT OR GUARDIAN _________________________School/Group____________________________
PRIMARY DISABILITY: _________________________OTHER DISABILITIES______________________
ADAPTATIONS: ________________________HAS STUDENT EVER RIDDEN A HORSE: Yes/ No
EMAIL____________________________________ Ethnic group: ________________________________

LIABILITY RELEASE

_________________(Rider's name) would like to participate in the SMILES program. I acknowledge the risks and potential for risks of horseback riding. However, I feel the possible benefits to myself/my son/my daughter/my ward 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 SMILES, its Board of Directors, Instructors, Therapist's, Aids, Volunteers and/or Employees for any and all injuries and /or losses I/my son/my daughter/my ward may sustain while participating in SMILES program.

Date: _______________Signature: ____
Client, Parent or Guardian

PHOTO RELEASE

I hereby consent to and authorize the use and reproduction by SMILES of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities or for any other use for the benefit of the program (Signature of this release is optional.)

Date: ______________Signature: ____
Client, Parent or Guardian

RIDER'S AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event that 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 SMILES 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.

Physician's Name: ____________________________Preferred Medical Facility______________________

Health Insurance Co. _____________________________________Policy # _________________________

EMERGENCY NUMBERS

IN CASE OF AN EMERGENCY or in the event that I cannot be reached: CONTACT:
____________________________PHONE_________________

OR CONTACT: ___________________________PHONE_________________

(PLEASE SEE OTHER SIDE)

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: ____________Print Name: ___________________________________Phone: ___________________

Address: ____

Consent Signature____

Client, Parent or Guardian

SMILES strives to provide the safest atmosphere possible, for this reason paperwork must be filled out completely. Any rider 150 pounds or more must be able to remain centered and balanced without requiring side-walkers. To insure the horse can safely carry their rider, SMILES cannot accommodate a rider over 200 pounds.

PHYSICIANS RELEASE

DIAGNOSIS____DATE OF ONSET_________________

NOTE: IF DOWN SYDROME, EVALUATE FOR ATLANTOAXIAL INSTABILITY.
DATE OF X-RAY___________POSITIVE______ NEGATIVE_______

Present medical and functional status (i.e. visual/audio limitations, seizures, balance, etc _________________)

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____**Allergies**______________________

Height______Weight________

Mobility: Independent ambulation Y N Assisted ambulation Y N Wheelchair Y N

In my opinion, this patient can receive therapeutic horseback riding instruction under appropriate supervision.

Physician Signature____

OR

Due to contraindications or SMILES determines mounted activities would be unsafe for this rider, this patient may participate in un-mounted activities.

Physician signature_______________________________________**Date**_____________________

SMILES
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