Pegasus Special Riders, Inc.

Therapeutic Horseback Riding

Rider Registration and Release

Today's Date:_____

Client Name:_____Date of Birth:_____Age:_____

Street:_____City:_____ State:_____ Zip:_____

Home Phone #: _____Work Phone #: _____ Emergency Phone #:_____

Parents/Guardian:_____

Address/Phone: (If different than client's)_____

Email Address:_____

School or Institution client presently attends: _____

In case of emergency, Contact:_____Phone:_____

Contact:_____Phone:_____

Liability Release

_____(Client's Name) would like to participate in the Pegasus Special Riders Therapeutic Riding Program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits 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 Pegasus Special Riders, its board of Directors, Instructors, Therapists, Aids, Volunteers and Employees for any and all injuries and/or loss the above named person may sustain while participating in the Pegasus Therapeutic Riding Program.

Date:_____Signature:_____

(Client, Parent or Guardian)

Photo Release

I hereby consent to and authorize the use and reproduction by Pegasus Special Riders, Inc. of any and all photographs and any other audiovisual material taken of me/my child/my ward for promotional printed material, educational activities for another use for the benefit of the program.

Date:_____Signature:_____

(Client, Parent or Guardian)

Proof of Guardianship may be requested. ID must be available upon registration.

Information for Physician

Client:_____ **Phone:**_____

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. When completing this form please note the conditions present and their degree. Comments on attached pages are acceptable.

Orthopedic

___ Spinal Fusion
___ Spinal Instabilities/Abnormalities
___ Scoliosis
___ Kyphosis
___ Lordosis
___ Hip Subluxation and dislocation
___ Osteoporosis
___ Pathologic Fractures
___ Coxas Arthrosis
___ Heterotopic Ossification
___ Osteogenesis Imperfecta
___ Internal Spinal Stabilization Device

Neurologic

___ Hydocephalus shunt
___ Spina Bifida
___ Tethered Cord
___ Chiri II Malformation
___ Hydroyelia
___ Paralysis due to Spinal Cord Injury
___ Seizure

Medical/Surgical

___ Allergies
___ Cancer
___ Poor Endurance
___ Recent Surgery
___ Diabetes
___ Peripheral Vascular Disease
___ Varicose Veins
___ Hemophilia
___ Hypertension
___ Serious Heart Condition
___ Stroke (Cerebrovascular Accident)

Secondary Concerns

___ Behavior problems
___ Age under two years
___ Age 2-4 years
___ Acute exacerbation of chronic disorder
___ Indwelling catheter

PEGASUS SPECIAL RIDERS, INC.

Medical History and Release

Name:_____Age:_____Date of Birth:_____

Address:_____City:_____State:_____Zip:_____

Parents/Guardian:_____

Diagnosis:_____Date of Onset:_____

Sex: Male Female Height:_____Weight:_____ P:_____B/P:_____

For Persons with Down Sydrome (or if they have Special Olympics Down Sydrome Athletic Evaluation)

Cervical X-Ray for Atlanto-Axial Instability; X-Ray Full Extension/Flexor of Neck

Pos:_____Neg:_____X-Ray Date:_____

Date of last Tetanus Shot:_____

Medications:_____

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

Problem	Yes	No	Description/Comment
Auditory Impairment			
Learning Disability			
Mental Impairment			
Psychological Impairment			(I.Q. if pertinent)
Speech Impairment			
Visual Impairment			Glasses or Contact Lenses
Allergies			
Cardiac			
Circulatory:			
PVD			
Hypertension			
Postural Hypotension			
Hemophilia			
Pulmonary: Asthma/COPD			
Neurological: Seizures			
Controlled			Type: Last Seizure:
Hydrocepalus			
Shunt			
Sensory Loss			
Spina Bifida			

PEGASUS SPECIAL RIDERS, INC.

Medical History and Release, Continued

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

Problem	Yes	No	Description/Comment
Muscular:			
Contractures			
Skeletal:			
Spinal Column Injury			(If yes, please describe)
Spinal Fusion			
Scoliosis Degree/type			(Brace/Last X-Ray)
Kyphosis/Lordosis			Degree/Type:
Spondylolisthesis			
Spinal Abnormality			
Osteoporosis			
Joint Disease			
Cranial Defects			
Pathologic Fractures			
Fractures			Location: Healed:
Other			
If Spinal Cord Involvement:			Vertebral Level:
Incontinent			
Catheter:			Foley -- Intermittent

Please indicate any medical problems not indicated above, include surgeries:_____

_____

Please indicate any special precautions:_____

_____

Mobility

Independent ambulation Yes No Crutches/Braces/Wheelchair: Yes No

If yes, describe: _____

Prosthetic/Orthotics

Type:_____Purpose:_____

Type:_____Purpose:_____

Please include any addition information that might help us to work with this student. (Including therapeutic goals)

I have examined and/or previously seen the above named individual and in my opinion/knowledge there is no mental or physical reason why they should not participate in the therapeutic horseback riding program at Pegasus Special Riders, Inc. under appropriate supervision. However, I understand that the therapeutic riding center will weigh the above medical information against existing precautions.

Physicians Signature:_____Date:_____

Print Physician's Name:_____Phone #:_____

PEGASUS SPECIAL RIDERS, INC.

Physician's Prescription

Client's Name:_____Phone:_____

Prescription for therapeutic horseback riding
Presciption, where appropriate for evaluation and treatment by a physical, occupational, and/or speech therapist in conjunction with the therapeutic horseback riding operating center.

Recommended Frequency:_____

Precautions:_____

_____

_____

_____

Physician's Signature:_____Date:_____

Please Print, Type or Stamp

Physician's Name_____

Address:_____

Phone:_____

PEGASUS SPECIAL RIDERS, INC.

Rider's Authorization for Emergency Medical Treatment Form

In the event emergency medical aid or 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 Pegasus Special Riders, Inc. to:

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

Client's Name:_____Phone:_____

Address:_____City:_____State:_____Zip_____

In the event I cannot be reached, Contact:_____Phone:_____

Contact:_____Phone:_____

Physician's Name:_____

Preferred Medical Facility:_____

Health Insurance Co.:_____Policy #:_____

Consent Plan

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

Consent Signature:_____Date:_____
(Client, Parent or Guardian)

Print Name:_____Phone:_____

Address (if different than above)_____

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 of emergency treatment/aid is required, I wish the following procedures to take place:_____

_____

Non-Consent Signature:_____Date:_____
(Client, Parent or Guardian)

Print Name:_____Phone:_____

Address (if different than above)_____

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM.

PEGASUS SPECIAL RIDERS, INC.

Rider's Consent for Release of Information

I hereby authorize:_____
(Person or Facility)

to release information from the record of:_____
(Client's name)

The information is to be released to Pegasus Special Riders, Inc. for the purpose of developing a therapeutic riding program for the above named client. The information to be release 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 (IEP)
____Other:_____

Date:_____Signature:_____
(Client, Parent or Guardian)

Please send the indicated material to
Pegasus Special Riders, Inc.
PO Box 293
Oregon, IL 61061