PO Box 293
Oregon, IL 61061
815-973-3177
pegasusspecialriders.org

Client Forms Checklist

- ☐ Registration & Release
- ☐ Health History
- ☐ Physician Statement (New Client & As Needed)
- ☐ AAI Statement (*Down Syndrome Only)
- ☐ Emergency Medical Release
- ☐ Consent for Release of Information
- ☐ Photo Release

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Client Registration & Release

Today's Date: _____________

Client Name: _________________________________ Date of Birth: ______________ Age: _______

Street Address: _________________________________ State: __________ Zip Code: ___________

Email: ____ Phone #: _____________________

Client Diagnosis (What qualifies rider for the program? List all relevant.) ________________________

____

Parent/Spouse/Guardian(s) Name: ____

Address if different from above: ____

In case if emergency:

Primary Contact Name: _______________________________ Relation to Client: _________________

Phone: ________________________ Email: ____

Alternate Contact Name: ______________________________ Relation to Client: _________________

Phone: ________________________ Email: ____

General & Equine Liability Release

I ____ (Client/Participant's Name) would like to participate in Pegasus Special Rider's programs. I acknowledge the risks and potential for risks of horseback riding and agree to assume all risks of personal injuries and damages regarding involvement in the program. However, I feel that the possible benefits to myself/my son/my daughter/ my ward are greater than the risk assumed. Therefore, in return for being permitted to participate and intending to be legally bound, for myself, my heirs and assigns, executors or Pegasus Special Riders, Inc. its Board of Directors, Property Owners, Sponsors, Instructors, Therapists, Aides, Volunteers, Visitors, Employees, Agents, or others on its behalf liable for any and all injuries and/or losses, I/my son/my daughter/my ward may sustain while participating in the Pegasus Special Rider's therapeutic horseback riding program and agree to indemnify them from all loss, expense, damages and costs they may incur by reason of any claim for damages brought against them. I have read, understand and agree to all the terms of this liability release and indemnity agreement.

Under the Equine Activity Liability Act, each participant who engages in an equine or animal activity expressly assumes the risks of engaging in and legal responsibility for injury, loss, or damage to person or property resulting from the risk of equine activities. ~IL PWA-89-0111~

Date: ________________ __Signature: ____

Adult *Client, Parent or Guardian*

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Health History

Client Height: ____________ Weight: ____________ *(Pegasus reserves the right to verify client weight as needed)*

Please indicate current or past special needs in the following systems/areas, including surgeries.

Problem/Condition	Y	N	Comments
Allergies			
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulation			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Changes in client's medical history/condition over the last year (e.g., physical, emotional or cognitive changes, major illness, surgeries)? Yes _______ No _______

If yes, please describe: ____

____

____

Medications that the client is currently taking, including any over-the-counter-medications (include dosage):

____

____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

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Health History (Continued)

Braces/Assisted Devices Used: ____

Other: Are there any other physical, emotional or cognitive changes that have occurred in the last year? If yes, please describe.

____

____

☐ *Initial* — I attest that this information is accurate (to the best of my knowledge). Pegasus Special Riders reserves the right to require an annual Medical History and Physician's Statement from any client.

☐ *Initial* — **I have read and agree to abide by the information in the Client Handbook including the financial and weather policies.** I agree to release, indemnify and hold Pegasus Special Riders (and its officers, directors and employees) harmless from any injury or loss arising out of any inaccurately reported or omitted medical information.

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Client's Medical History & Physician Statement

Date: ________________

Dear Health Care Provider,

Your patient ___________________________________ is interested in participating in supervised equine activities.

To safely provide this service, Pegasus Special Riders Inc. requests that you complete/update the attached Medical History and Physician Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present to and to what degree.

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbation of Medical Conditions (e.g., RA, MS)
Fire Setting
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorder
Weight Control Disorder
Cancer
Diabetes

Other
Age - under 4 years
Indwelling Catheters
Medications (e.g., Photosensitivity)
Poor Endurance
Skin Breakdown

Orthopedic
Atlantoaxial Instability - include neurologic symptoms
Coxarthrosis
Cranial defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities
Scoliosis
Kyphosis
Lordosis

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida
Chiari II Malformation
Tethered Cord
Paralysis due to Spinal Cord Injury

Thank you for your assistance. If you have questions or concerns regarding this patient's participation in equine-assisted services, please feel free to contact Pegasus Special riders at 815-973-3177 or admin@pegasusspecialriders.org.

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Participant's Medical History & Physician Statement

Participant: ______________________________ DOB: __________ Height: _________ Weight: __________

Address: ____

Diagnosis: ____ Date of Onset: ______________

Past/Prospective Surgeries: ____

Medications: ____

Seizure Type: ________________________________ Controlled: Y N Date of Last Seizure: _____________

Shunt Present: Y N Date of last revision: ____

Special Precautions/ Needs: ____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: ____

For those with Down syndrome: Neurologic Symptoms of Atlantoaxial Instability (circle one): Present Absent

Please indicate current or past special needs in the following systems/areas, including surgeries.

	Y	N	Comments
Allergies			
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulation			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted services. I understand that Pegasus Special Riders will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the Pegasus Special Riders center for ongoing evaluation to determine eligibility for participation.

Name/Title: ____ MD DO NP PA

Signature: ____ Date: ______________

Address: ____

Phone: ___________________________ License/UPIN Number: ___________________________

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AAI Medical Release

(For clients with Down Syndrome Only)

Client Name: ____________________________________ DOB:______________________________

I have completed a neurological examination for symptoms consistent with atlantoaxial instability (AAI) and focal neurologic disorder.

After completion of the neurological exam, the individual named above does not reveal sign of AAI or decrease in neurologic function.

☐ Yes

☐ No

Comments: ____

____

____

In my professional opinion, the individual named above may participate in mounted equine activities:

☐ Yes

☐ No

Additional Information:
(For the safety of our horses, if the height and weight information is not completed and initialed by the physician, we reserve the right to collect this information on-site, at Pegasus Special Riders. Physician signature required.)

Rider Height _____________ Physician initial: _____________

Rider Weight _____________ Physician initial: _____________

Physician's Signature/Stamp: ___________________________________ Date: _________________

Physician's Name: ____

Street: ____ State: __________ Zip Code: __________

Phone: __________________________________

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Authorization for Emergency Medical Treatment Form

☐ Participant ☐ Staff ☐ Volunteer

Name: ____________________________________ DOB: ____________________ Phone: __________________________

Street Address: ____ State: _____________ Zip Code: ______________

Physician's Name: ____________________________ Preferred Medical Facility: __________________________________

Health Ins Co: ____ Policy #: ___________________________________

Allergies to medications: ____

Current medications (include dosage): ____

____

Medical Conditions/Special Accommodations Needed: ____

____

I have supplied the information requested above to the best of my knowledge and ability. The above information is up to date and current.

Participant/Parent/Legal Guardian Signature: ____ **Date:** _______________

In the event of an emergency, contact:

Name: ____ Relation: _______________________ Phone: _________________

Name: ____ Relation: _______________________ Phone: _________________

In the event of emergency medial aid/treatment is required due to illness or injury during the process of receiving services or while on the property of the agency, I authorize Pegasus Special Riders to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon reque3st to the authorized individual or agency involved in the medial emergency treatment

Consent Plan:
This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: _________________ Signature: ____
Client, Parent or Legal Guardian

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:

☐ Parent or legal guardian will always remain on site during equine assisted activities.

☐ In the event emergency treatment/aid is required, I wish the following procedure to take place.

____

Date: _________________ Signature: ____
Client, Parent or Legal Guardian

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Consent for Release of Information

Pegasus Special Riders will not use or share your health information without written permission unless authorized by law.

I hereby authorize the listed (persons or facilities) ____

to release information from the record of (client name): ____

Complete address and phone number of person(s) and/or facilities listed above:

____

____

____

The information is to be released to Pegasus Special Riders for the purpose of developing an adaptive riding program for the above-named client. 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
_____Mental Health evaluation, assessment and program plan
_____Individual Habilitation Plan (I.H.P.)
_____Classroom Individual Education Plan (I.E.P.)
_____Cognitive-Behavioral evaluation, assessment, and/or management plan
_____Other

This release is valid for one year and can be revoked in writing, at my request. Please send materials to the address listed above.

Signature(s): ____Date:_________________

Relationship to Client ____

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Photo Release

Please print the names below for clients, caregivers, spouses, guardians, and minor children who may accompany the client to the farm. Circle "Do" or "Do Not" to grant consent/non-consent.

Client/Volunteer/Staff Name:____ **DO or DO NOT**

Caregivers/Guardians of Minor children:_____________________________ **DO or DO NOT**

____

hereby grant irrevocable and unlimited consent to the use and reproduction by Pegasus Special Riders Inc., its assigns, licensees and legal representatives, of all photographs and any other audio/visual materials taken of me, my child or my ward, in all forms and media (including but not limited to printed media, digital media, web sites, video and audio productions). The materials may be reproduced in all forms including composite, altered or derivative works, for promotional material, educational activities, exhibitions or for any other lawful use for the benefit of the program.

I hereby waive the right to inspect and approve the finished version(s) including any copy that may accompany the materials. I hereby release Pegasus Special Riders, and its employees, volunteers, assigns, licensees and legal representatives from all claims and liability relating to said materials. I sign this release as a person with, or the parent or guardian of a person with special needs, understanding that use of these materials will make them available to the public.

I have read and understand the above release, am over 18 and have the capacity to sign this release of my own free will.

Signature:____Date:_________________

OR:

I am the parent/spouse/guardian of the client named above and have the legal authority to execute the above release. I approve the foregoing and waive any rights in the premises.

Signature:____Date:_________________