2024 WEEKLY LESSON REGISTRATION FORM

PARTICIPANT NAME: _____

DOB: _____ AGE: _____ GENDER: □ Male Female □ Other: _____

PRIMARY CONTACT (If under 18 or Guardian): _____

PHONE: _____ EMAIL: _____

MAILING ADDRESS: _____

If applicable: SECONDARY CONTACT NAME: _____

PHONE # _____ EMAIL _____

Preferred contact method for last minute lesson cancellations: □ Phone Call □ Text Message □ Email

I have read, understand, and agree to TRI's lesson policies that are found in the Participant's Handbook.

Signed _____Date_____

Student (over 18), Parent or Guardian

CLASS REGISTRATION INFORMATION FOR 2024 LESSON SEASON

REGISTRATION DEADLINES:

Spring: January 26th **Summer:** May 1st **Fall:** August 25th

SESSION'S INTERESTED IN RIDING:

□**Spring (**Feb 19-May 3**)** □ **Summer 1 (**May 20-Jun 22**)** □ **Summer 2 (**Jul 15-Aug 17) □ **Fall (**Sep 9-Nov 23**)**

Please Select Your Top 3 Choices for Day You Are Available and Mark Your Preferred Timeslot(s):

Each hour indicates the start time of the lesson

___ Monday □ 2:00pm □3:00pm □4:00pm □5:00pm □6:00pm □7:00pm □8:00pm

___ Tuesday □ 2:00pm □3:00pm □4:00pm □5:00pm □6:00pm □7:00pm □8:00pm

___ Wednesday □2:00pm □3:00pm □4:00pm □ 5:00pm □6:00pm □7:00pm □8:00pm

___ Thursday □10:00am □11:00am □12:00pm □3:00pm □4:00pm □5:00pm

□ 6:00pm □ 7:00 pm □ 8:00pm

___ Saturday □9:00am □10:00am □11:00am □12:00pm

TRI PARTICIPANT INFORMATION (Must be completed annually)

Participant Name_____

Primary Diagnosis _____

Secondary Diagnosis _____

DOB _____ Height _____ Weight_____

Participant is a (mark one) Minor ☐ Adult w/ a Legal Guardian ☐ Independent Adult ☐

Does the Participant Reside somewhere other than with the Parent/Legal Guardian? If yes, list address and phone:

_____

_____

How did you hear about TRI? _____

Is the Participant in School? Yes □ No □ What Grade Level? _____Special Needs □ Typical Class □

School System _____

For Grant Purposes:
□ Caucasian □ Asian □ Hispanic/Latino □ African American □ Native American □ Other
□Veteran □ Dependent of Veteran What county do you reside: _____

Has the student had prior experience with therapeutic riding? Yes □ No □
If yes, when and where? _____

HEALTH HISTORY TO BECOMPLETED BY PARTICIPANT

A PHYSICIAN'S RELEASE MUST BE ON FILE. SEE ADDITIONAL FORMS

Current Therapies and How Often (PT, OT, Speech, Respiratory) _____

_____

Please Circle All Applicable to Participant

Asthma	Inhaler	EpiPen	Allergies – Type	
Independent Ambulation	Walker	Wheelchair	Brace - Type=	Shunt*
ALS Interpreter	Service Dog	Visual Assistance	Emotional Support	Catheter*

For Participants who use a Wheelchair, Please Complete

Wheelchair Only Aids Ambulation Sometimes	Sits Up Unassisted
Support Through Trunk Required	Full Support of Head and Neck Required

PARTICIPANT NAME: _____

Yes	Participant with or is Treated For:	Date(s)	Comments
	Down Syndrome		
	Brain Condition i.e. Cerebral Palsy, stroke		
	Spinal Condition i.e. Spina Bifida, Scoliosis, Fusion, Injury		
	Medical Device Implanted (insulin pump, catheter, colostomy)		
	Seizure Disorder		
	Diabetes		
	Joint complications i.e. dysplasia		
	Bleeding or clotting disorders		
	Heart Condition		
	Neurological condition		
	Muscular Disorder		
	Medical Shunt or Feeding Tube		
	Epilepsy		
	Mental Health Crisis		
	Pulmonary condition		
	Violent Outbursts		
	Have altered sensation? (specify)		

IN THE PAST 12 MONTHS, HAS THE PARTICIPANT EXPERIENCED ANY OF THE FOLLOWING

YES	ISSUE	DATE	EXPLANATION
	Loss of consciousness, including seizures		
	Hospitalized for mental health crisis		
	Hospitalized (injury, surgery, etc)		
	Activities been restricted due to medical reasons		

If you answered YES to any of the above conditions, a Physician's Release MUST be completed annually.

I confirm that the information provided is accurate and true as it pertains to the listed participant,

_____

Name of Person Completing Form Signature Date

TRI PARTICIPANT CONSENTS & RELEASES

Participant Name: _____DOB _____

Parent/Guardian/Caregiver: _____

Address: _____ City _____ Zip: _____

Phone: Home _____Cell _____ Work: _____

Emergency Contact
If the above cannot be reached, I authorize these people be contacted and participant can be placed in their care.

Name _____ Relationship_____ Phone _____

Physician: _____ Phone: _____

Medications & Dosage:

_____

Please list all known medication allergies: _____

Medical Conditions an Emergency Medical Team needs to know about: _____

_____

_____

Insurance Carrier: _____Policy Number: _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

In the event of a medical emergency, TRI will provide basic first aid and/or call 911. Personal Health Information will be disclosed as necessary to medical personnel.

☐ **I Give Consent for Emergency Medical Care as Stated Above**

☐ **I Do NOT Give Consent for Emergency Medical Care. I will not hold TRI responsible my decision to withhold consent. In the event emergency care is required, I wish the following procedures take place:**

_____

_____

_____

Signature: _____Date: _____

Parent/Guardian/Caregiver: _____ Date: _____

PARTICIPANT NAME: _____ **DOB:** _____

PHOTO RELEASE

☐ I DO ☐ I DO NOT consent to and authorize the use and reproduction by TRI of any and all photographs and any audio-visual materials taken of me/my son/my daughter/my ward for promotional material, educational activities, exhibitions and digital displays or for any other use for the benefit of the program. With respect to the foregoing matters, no inducements or promises have been made to secure this signature to this release other than the intention of TRI to use, or cause to be used, such photographs, films, and pictures for the primary purpose of promoting TRI and its work. TRI will strive to keep individuals' identities secure while using photos in newspapers, informational materials, website, Facebook, and other media materials. Likewise, NO photos or images shall be taken of TRI participants, staff or volunteers and used for personal social media (print, broadcast, digital and online) by a participant or their guests without express permission by all parties involved.

Statement of Understanding, Authorization Release, and Indemnity

_____ (Participant's Name) would like to participate at The Therapeutic Riding Institute, Inc. I acknowledge the risks and potential for risks of Equine Assisted Activities and Therapies. However, I feel that 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 any potential claims for damages against the Therapeutic Riding Institute, Inc. In return for the opportunity to participate in the TRI program, I hereby forever release, acquit and discharge TRI and its officers, directors, trustees, agents, employees, representatives, volunteers, affiliates, successors and assigns (collectively the "Released and Indemnified Parties") from any and all claims, demands and causes of action of any and every kind or nature, including those caused in whole or in part by the negligence of any of the Released and Indemnified Parties, which I may now or in the future have against any or all of the released and Indemnified Parties and that arise in whole or in part as a result of my involvement with TRI. I also understand and agree that TRI assumes no liability for accidents or acts of negligence or gross negligence by anyone, including the Released and Indemnified Parties. I further agree to fully indemnify and defend any of the Released and Indemnified Parties against any and all claims, demands or causes of action of any and every kind or nature (including attorney's fees and other defense costs), including those caused in whole or in part by the negligence of any or all of the Released and Indemnified Parties, which directly or indirectly relate to personal injuries or property damages sustained by me and that arise in whole or in part as a unenforceable, all other provisions shall remain in full force and effect.

Ohio Statement of Inherent Risks:

Inherent risk of an "equine activity" means a danger or condition that is an integral part of an equine activity, including, but not limited to, any of the following:

A. The propensity of an equine to behave in ways that may result in injury, death, or loss to persons on or around the equine;

B. The unpredictability of an equine's reaction to sounds, sudden movement, unfamiliar objects, persons, or other animals;

C. Hazards, including, but not limited to, surface or subsurface conditions;

D. Collision with another equine, another animal, a person, or an object;

E. The potential of an equine activity participant to act in a negligent manner that may contribute to injury, death, or loss to the person of the participant or to other persons, including but not limited to, failing to maintain control over an equine or failing to act within the ability of the participant.

Adult Participant Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

I represent to TRI that I am the parent or guardian of the Applicant whose signature appears above. I am authorized to sign this Statement on behalf of the Applicant and my doing so legally binds the Applicant as if he or she were not a minor.

PHYSICIAN RELEASE

(ALL PARTICIPANTS MUST HAVE THIS FORM COMPLETED ANNUALLY PRIOR TO PARTICIPATING IN EQUINE ASSISTED ACTIVITIES)

TO PHYSICIAN COMPLETING RELEASE,

This person is registering to participate in Equine Assisted Services. Horseback riding has inherent risks; however, some medical conditions are contraindicated due to a variety of factors relating to the activity. Please consider this when completing this form.

Name: _____Date of Birth: _____Age: _____

Name of Parent/Guardian: _____

Primary Diagnosis: _____Date of Onset: _____

Secondary Diagnosis: _____

Height ___ft ___in Weight _____lbs. Date of Last Tetanus Shot: _____

Down Syndrome: Neurological Symptoms of Atlantoaxial Instability: Present_____Absent_____
Date of AI testing: _____Result: _____

Please Mark All That Apply To this Patient

Asthma	Inhaler	EpiPen	Allergies - Type	
Independent Ambulation	Walker	Wheelchair	Brace - Type=	Catheter Type=

For Patients Who Use a Wheelchair, Please Circle

Wheelchair Only Aids Ambulation Sometimes	Sits Up Unassisted
Support Through Trunk Required	Full Support of Head and Neck Required

Please Indicate All Areas Involved

	Description
Cardiovascular	
Spinal Condition i.e., Spina Bifida, Scoliosis, Fusion, Injury	
Medical Device Implanted (insulin pump, catheter, colostomy)	
Diabetes	
Musculoskeletal – Body Part	
Bleeding or clotting disorders	
Neurological condition	

Participant Name: _____

Mental Health Crisis	
Pulmonary condition	
Have altered sensation? (specify)	

For Patient's with a History of Seizures

Date of Last Seizures _____ Frequency of Seizures _____

Type of Seizures _____

Typical Causes of Seizure Activity _____

_____

How does Seizure Present _____

_____

TO BE COMPLETED BY PHYSICIAN ONLY

I have examined the above-named participant and, given the participant's diagnosis and health history, this person does not present apparent clinical contraindications for equine sports. I understand The Therapeutic Riding Institute will weigh the medical information provided against the existing precautions and contraindications; therefore, I refer this person to The Therapeutic Riding Institute for ongoing evaluation to determine eligibility for participation.

□ I Agree There Are No Contraindications to Mounted Riding Lessons
□ Mounted Riding Lessons is NOT Recommended, but Unmounted Lessons are Not Limited
□ Restrictions include _____

_____

Physician name (please print) _____

Physician Signature _____ Date _____

Medical Practice Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Please Return Completed Form to Participant to:

3960 Middle Run Road, Spring Valley, OH 45370
Email to: SIngersoll@TRIOhio.org
Fax to: 937-317-4814