



NEW RIDER REGISTRATION
THERAPEUTIC RIDING & HIPPOThERAPY
(Pilot Program)

Participant's Name: _____ Date: _____

Type of Riding: *(circle one)* Speech Hippotherapy Occupational Hippotherapy
 Physical Hippotherapy Therapeutic Riding

Date of Birth: _____ Sex: _____ Height _____ Weight _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Email: _____

Primary Disability: _____ Secondary Disability: _____

If under 18, please complete the following:

Father: _____ Phone: _____ Email: _____

Mother: _____ Phone: _____ Email: _____

Name/Address/Phone numbers *(if not parents)* of _____ Legal Guardian or _____ Caregiver

How did you hear about Cross Creek Meadows Therapeutic Riding Center? _____

Availability: After the rider's assessment, you will be contacted for scheduling. Once the schedule is set, you will be sent a confirmation of your riding time.

In the event that Cross Creek Meadows has to cancel more than one week of classes during a session due to inclement weather, please check one of the following options for your remaining lesson fees:

_____ Credit toward the following session

_____ Donate the amount to the Rider Financial Assistance Fund

Please Note: Classes that students miss without prior notice to the center may be subject to cancellation fees.

Leftover financial assistance will automatically be credited back to the Rider Assistance Fund



AUTHORIZATION FOR EMERGENCY MEDICAL

Participant's Name: _____

(Please Print)

In case of Emergency, please contact _____	Phone(s) _____
Physician's Name: _____	Phone: _____
City: _____	
Please indicate any allergies _____	
Please indicate any medical issues that may effect your/your child's participation at Cross Creek Meadows: _____	

Date of last Tetanus Shot: _____

CONSENT PLAN: I give consent for emergency medical treatment/aid (including x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physicians). In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, any participation on my part at Cross Creek Meadows, or while being on the property of Cross Creek Meadows, I authorize Cross Creek Meadows Therapeutic Riding Center to:

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

Participant's Consent Signature _____ Date: _____

Signature of Parent/Guardian _____

(If participant is under 18 years of age)

NON-CONSENT PLAN: I do not give consent for emergency medical treatment/aid in the event of illness or injury during the process of receiving services, any participation on my part at Cross Creek Meadows, or while being on the property of Cross Creek Meadows Therapeutic Riding Center. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Participant's Signature _____ Date: _____

Signature of Parent/Guardian _____

(If participant is under 18 years of age)



PHOTO RELEASE

_____ I consent to and authorize _____ I do not consent to nor to I authorize the use and reproduction by Cross Creek Meadows Therapeutic Riding Center of any and all photographs and any other audiovisual materials taken of me or my child for promotional printed material, educational activities, or for any other use for the benefit of the program.

Name _____

Participant's Signature _____ Date: _____

Signature of Parent/Guardian _____

(If participant is under the age of 18)

POLICY OF CONFIDENTIALITY

I agree to respect and observe the privacy and confidentiality of the participants, volunteers, and donors of Cross Creek Meadows Therapeutic Riding Center and not discuss or disclose any sensitive information about any person or their family.

Name _____

Participant's Signature _____ Date: _____

Signature of Parent/Guardian _____

(If participant is under the age of 18)



LIABILITY RELEASE

That I, _____ or that I, the undersigned parent or legal guardian of _____, a minor, for and in sole consideration of the privilege of permitting said person to participate in activities at or sponsored by Cross Creek Meadows Therapeutic Riding Center (CCMTRC) and recognizing that horseback riding activities involve inherent dangers and risks to persons and property, do hereby agree to assume for myself and on behalf of my ward or child, the risks and dangers attendant to such activity, including by not limited to: falling or being thrown from a horse, being kicked, stepped on or bitten by a horse or other animal, and/or injuries sustained while riding, mounting or dismounting a horse. I further acknowledge the risks and potential for risks associated with recreational and outdoor activities, including but not limited to: snake, animal or insect bites; uneven ground; sun, cold, and wind exposure; cuts and scrapes; sore or pulled muscles; broken, dislocated or fractured bones; nerve damage; internal injuries; head injuries, grievous bodily injury or death. However, I feel that the possible benefits to child, ward, or myself are greater than the risk assumed.

I hereby, intending to be legally bound, for myself and my child or ward, heirs, and assigns, executors or administrators, waive and forever release, acquit, discharge and hold harmless all claims for damages against CCMTRC, its board of directors, trustees, agents, instructors, therapists, employees, representatives, volunteers, owners of property on which CCMTRC operates, successors, or assigns on account of any personal injuries and/or personal damages known or unknown, or in anyway growing out of the acts of CCMTRC, its board of directors, trustees, agents, instructors, therapists, aids, employees, representatives, volunteers, owners of property on which CCMTRC operates, successors or assigns.

WARNING

I understand that under Texas Equine Liability Act (Chapter 87, Civil Practice and Remedies Code), an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities.

I, the undersigned, have read this waiver of liability in its entirety. I understand the terms of this release and have signed this release voluntarily and with full knowledge of the effect thereof.

Name _____

Participant's Signature _____ Date: _____

Signature of Parent/Guardian _____

(If participant is under the age of 18)



PHYSICIAN ASSESSMENT & PERMISSION

--To be completed by Physician--

Client's Name: _____ Date of Birth: _____

Diagnosis:

Primary: _____ Date of Onset: _____

Secondary: _____ Date of Onset: _____

Other: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizures: ____ No ____ Yes Type: _____ Date of last seizure: _____

Shunts/Implants: _____

Mobility: Independent Ambulation: ____ Yes ____ No Assisting Devices _____

In order to safely provide this service, CCMTRC, requests that you please note that the following conditions may suggest precautions and contraindications to equestrian activities. Therefore, when completing this form, please indicate whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability- include neurological symptoms

Coxa Arthrosis

Cranial Deficits

Heterotopic Ossification/Myositis Ossificans

Joint subluxation/dislocation

Osteoporosis

Pathologic Fractures

Spinal Joint Fusion/Fixation

Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt

Seizures

Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other

Indwelling Catheters/Medical Equipment

Medication- ie. Photosensitivity

Poor Endurance

Skin Breakdown

Medical/Psychological

Allergies

Animal Abuse

Cardiac Condition

Physical/Sexual/Emotional Abuse

Blood Pressure Control

Dangerous to self or others

Exacerbations of medial conditions (ie: RA, MS)

Fire Settings

Hemophilia

Medical Instability

Migraines

PVD

Respiratory Compromise

Recent Surgeries

Substance Abuse

Thought Control Disorders

Weight Control Disorders



Client's Name: _____

As thoroughly as possible, please indicate current or past difficulties/symptoms in the following systems/areas that apply, including surgeries.

Area	No	YES	Degree/Comments
Auditory			
Visual			
Speech			
Tactile/Sensory			
Cardiac			
Circulatory			
Pulmonary			
Integumentary/Skin			
Immunity			
Neurologic			
Muscular			
Orthopedic			
Bowel/Bladder			
Learning Disabilities			
Cognitive			
Emotional/Psychological			
Behavior			
Other			

For those with Down Syndrome

An Atlantoxial x-ray and annual exam to exclude Atlantoxial instability is required for clients with Down Syndrome over the age of 3.

Date of X-ray: _____ Results: _____

Neurologic Symptoms of Atlantoxial instability: _____

Given the above diagnosis and medical information, this person is not medically precluded from participation in supervised equestrian activities. I understand that CCMTRC will weigh the medical information indicated above against any existing precautions and/or contraindications before accepting this person for therapeutic horseback riding lessons. Therefore, I refer this person to CCMTRC for ongoing evaluation to determine eligibility for participation.

Name/Title : _____ MD, DO, NP, PA OTHER: _____

Signature: _____ Date: _____

Address: _____

Phone: _____ License/ UPIN Number: _____



Cross Creek Meadows Therapeutic Riding Center and Barn Rules

Note: Horses are prey animals. They may instantly become unpredictable if scared or confused. Always use caution around all horses. Parents, you are responsible for the actions and conduct of your children at all times.

1. Safety is always paramount in this barn.
2. Stay out of barn stalls. Do not pet the horses in the stalls.
3. Park in the designated area in front of the building. Do not block another car.
4. Do not drive past the CCMTRC barn into back of the property.
5. Do not park under the covered entrance to the barn. Use area to drop off only.
6. Speed limit is 10 MPH. Please be considerate of riders in the arena as you drive in.
7. Use caution around horses. No running, screaming, or unruly behavior in the barn.
8. Never stand directly in front of or behind a horse.
9. Do not go into pastures, paddocks, or round pens where horses are present.
10. Do not feed the horses treats.
11. Unsupervised children are not allowed at this facility at anytime. Please keep your children with you at all times.
12. Treat all equipment with care. Return helmets, tack, grooming buckets, toys, comes, and tools to their proper place after use.
13. Dress appropriately: long pants, shoes with heels (preferable boots) and a helmet are required.
14. Helmets must be worn by all students whether doing groundwork or riding.
15. No animals other than horses are allowed on the premises of the barn.
16. No bikes or skateboards allowed.
17. No alcoholic beverage or smoking allowed on premises.
18. Do not enter stalls with a horse.
19. As of September, 1995, Texas enacted the following Law: Texas Law (*Chapter 87, Civil Practice and Remedies Code*), *an equine professional is not liable for the injury or the death of a participant in equine activities resulting from the inherent risks of equine activities.*

I have read and understand what is written and agree to follow the rules and regulations set forth by Cross Creek Meadows Therapeutic Riding Center. I understand and am aware of the Texas Equine Liability Act.

Participant's Signature _____ Date: _____

Signature of Parent/Guardian _____

(If participant is under 18 years of age)