Saddle Up Riding Club Inc.
PSALM 33: 17-19
Equine Therapy Center

Participant Registration Information- Please Write clearly in Ink.

Rider Full Name:_____Date of Birth:_____
Address:_____City:_____Zip:_____
Home Phone:_____Cell Phone:_____Alt #:_____
E-mail address: _____
School or Institution presently attending:_____

Parent or Legal Guardian Information [If applicable]

Father / Guardian Name:_____
Primary Phone:_____Secondary:_____
Address [If different from above]:_____
Mother / Guardian Name:_____
Primary Phone:_____Secondary:_____
Address [If different from above]:_____
Caregiver Name & Phone number:_____

Photo Release

I hereby consent to and authorize the use and reproduction by Saddle Up Riding Club and the City of Pinellas Park 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:_____Date:_____
(Adult Signature: Parent or Legal Guardian for Minor Child)

Rider Authorization for Emergency Medical Treatment

In the event 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 Saddle Up to:

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

I give 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. 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.

In an emergency Contact

Contact 1:_____Phone:_____
Contact 2:_____Phone:_____
Physician Name:_____Phone:_____
Preferred Medical Facility:_____
Health Insurance Co:_____Policy:_____
Signature:_____Date:_____
(Adult Signature: Parent or Legal Guardian for Minor Child)
Participant Full Name:_____Date of Birth:_____

Saddle Up Riding Club, Inc.

Participant Registration Information- Please write clearly in Ink.

UNCONDITIONAL GENERAL RELEASE

WARNING-UNDER FLORIDA LAW, 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 _____, a participant, client, volunteer, or student of the legal guardian of a participant, client, volunteer, or student ("Participant") in a program, event, or activity taking place under the sponsorship of or at the facilities of **Saddle Up Riding Club, Inc.**, a Florida not for profit corporation ("Saddle Up"), hereby give consent and approval to the participant in any and all programs, events, or activities taking place under the sponsorship of or at all the facilities of Saddle Up ("Activities"). I fully understand that my decision to be a Participant, or to allow such person named above to be a Participant, poses risks of personal injury, property damage, death and/or other loss that may arise while participation in the Activities. I assume all risk and the hazards incidental to the conduct of the Activities as well as transportation to and from all Activities. In consideration of Participants' being allowed to participate in the Activities, on behalf of the Participant, Participant's heirs, personal or legal representatives, successors and assigns, I hereby irrevocably and unconditionally release, and Covent not to sue Saddle Up Riding Club, Inc, Lucky C Ranch, Scott and Angela Coleman, directors, officers, employees, agents, independent contractors, representatives attorneys, successors and assigns, and all persons acting by, through, under or in concert with any of them (collectively "the Releases'"), from any and all claims or causes of action whatsoever, in law or in equity, whether known or unknown at this time, based on action, cause or thing occurring on, prior to, or following the date hereof, and, in particular, without limiting the generality of the foregoing, all claims arising out of or relating to the activities, even if such liability or damage results from the sole negligence of the Releases'.

I hereby authorize the Releases' to act in their discretion on behalf of participant in providing, requesting, or authorizing the provision of emergency medical services ("Emergency Services"). I acknowledge full responsibility for any charges associated with the rendering of any and all Emergency Services and I indemnify the Releases from any and all claims, expenses, or other charges related to their decision to provide or to not provide Emergency Services. I understand and agree that this document shall be constructed according to the laws of the State of Florida, and that this Unconditional General Release shall be as broad and inclusive as is permitted by the laws of the State of Florida, If any portion of this document is held to be invalid of of no force of effect, I agree that the balance shall continue in full force and effect.

This Unconditional General release shall be immediately effective upon its execution.

I HAVE READ AND UNDERSTAND THIS DOCUMENT DATED this ___ day of _____

Signature of [ ] Participant, [ ] Parent or [ ] Legal Guardian _____

Printed Name of [ ] Participant, [ ] Parent or [ ] Legal Guardian_____

Saddle Up Riding Club, Inc.
9301 62nd St. Pinellas Park,
FL. 33782
Voice: (727) 520-3132
www.saddleupridingclub.org

Riders Medical History and Physician's Release – Must be completed by Physician

Name:_____ DOB:_____Height:_____Weight_____
Address:_____
Name of [ ] Parent or [ ] Guardian:_____
Primary Diagnosis:_____Date of Onset:_____
Secondary Diagnosis:_____Date of Onset:_____
Tertiary Diagnosis:_____Date of Onset:_____
Shunt Present: Y N Date of Last Revision:_____ Tetanus shot: Y N: Date if Yes:_____
Seizure Type:_____Controlled: Y N Date of last Seizure:_____
PLEASE LIST ALL CURRENT MEDICATIONS

1._____Taken for_____
2._____Taken for_____
3._____Taken for_____
Any contagious diseases:_____

Please indicate if a patient has a problem and/or surgeries in any of the following areas. If yes, please comment, using the back of the form if necessary.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disabilities			
Mental Impairment			
Psychological			
Impairment			
Incontinence			

Coordination			
Balance			

Mobility: independent Ambulation: Yes_____No____ Crutches: Yes_____ No_____

Wheelchair: Yes_____ No_____ Braces: Yes_____ No_____

Past/ Prospective Surgeries:_____

Special Precautions/Needs:_____

Physician's signature required on the other side

Physician Information

The following conditions, if present, may represent precautions and contraindications to therapeutic horse riding. Please be sure to clearly identify and check the boxes if any of the following conditions are present and explain to what degree.

Orthopedic		**Medical/Surgical**	
Spinal Fusion		Allergies	
Spinal Instabilities/ Abnormalities		Cancer	
Internal Spinal Stabilization Devices		Poor Endurance	
Atlantoaxial Instabilities		Recent Surgery	
Scoliosis		Diabetes	
Kyphosis		Peripheral Vascular Disease	
Lordosis		Varicose Veins	
Hip Subluxation and Dislocation		Hemophilia	
Osteoporosis		Hypertension	
Pathologic Fractures		Serious Heart Condition	
Coxas Arthrosis		Stroke (Cerebrovascular Accident)	
Heterotopic Ossification			
Osteogenesis imperfecta		**Neurologic**	
Cranial Deficits		Seizure disorders	
Spinal Orthoses		Hydrocephalus/shunt	
Secondary Concerns		Spina Bifida	
Behavior Problems		Tethered Cord	
Age two – four years		Chiari ll Malformation	
Acute exacerbation of chronic disorder		Hydromyelia	
Indwelling catheter		Paralysis due to Spinal Cord Injury	
Integumentary/ Skin			

Riders with Down Syndrome- PLEASE NOTE

Due to the nature of the activity of horseback riding, no individual diagnosed with Down Syndrome can be accepted for riding instruction without proof of a negative diagnostic x-ray for Atlantoaxial Instability. Pleas provide the following information:

a) Most recent cervical x-ray for AAI: [ ] Positive [ ] Negative…Date of X-Ray_____
b) Annual cervical exam for AAI: [ ] Positive [ ] Negative…Date of Exam_____

Physician Verification -- Please PRINT your name, sign & date – THANK YOU

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications.

THIS MUST BE FILLED OUT AND SIGNED BY PHYSICIAN TO ENTER THE EQUINE THERAPY PROGRAM .

Physician Name/Title: (please print):_____
Signature:_____Date:_____Phone:_____
Address:_____
Additional Comments:_____

Saddle Up Riding Club, Inc. – Rider Questionnaire

The following questionnaire is designed to give Saddle Up Riding Club, Inc. Information pertaining to each individual rider's behavior and ability. This will help us prepare group lesson plans and assist you in attaining individual goals. Please complete this questionnaire in as much detail as possible using the back of the page or attaching additional sheet if necessary.

Name:_____ Age:_____

1. Briefly describe his/her disability:_____

   _____

   _____

2. What are the physical symptoms of the disability?_____

   _____

   _____

3. What goals do you hope he or she will achieve by participating in this program?_____

   _____

   _____

4. What other treatments or therapies has he/she undergone? Please specify when and for

   how long:_____

5. How would you describe his/her concentration, attention span and general awareness?

6. Would you characterize him/her as happy, aggressive easygoing, enthusiastic, passive, excitable, depressed, introverted or extroverted?

7. How does he/ she communicate? (Expressive and Receptive Language)

8. Is there a history of incontinence?

9. What positive reinforcements does he/she respond to?

10. Please use the rest of this sheet / the reverse side to indicate any other areas of the potential rider's behavior and personality that will help us to best communicate, understand and work with him/her at Saddle Up Riding Club, Inc.

Completed by:_____ Date:_____

Relationship to Rider:_____

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RELEASE AND HOLD HARMLESS AGREEMENT

WHEARAS, the UNDERSIGNED acknowledges the inherent risks involved in riding and working around horses, which risks include bodily injury from using, riding, or being in close proximity to horses, among other risks, and further, that both horse and rider can be injured in normal use or in competition and schooling. IN CONSIDERATION, therefore, for the privilege of riding and working around horses at SADDLE UP RIDING CLUB, INC. The undersigned does hereby agree to hold harmless and indemnify KELLIE AND JEFF SIPOS OR THE OWNER OF ANY HORSE USED BY THE SADDLE UP RIDING CLUB, INC, SADDLE UP VOLUNTEERS AND BOARD MEMBERS and SCOTT AND ANGELA COLMAN, LUCKY C RANCH and release them from any liability of responsibility for accident, damage, , or illness to the Undersigned or any horse owned by the Undersigned or to any family member or spectator accompanying the Undersigned on the premises of Saddle Up Riding Club 9301 62nd Street, Pinellas Park, FL. 33782

Date:_____

Participants printed name and address: _____

_____

All family members may be listed on one sheet:_____

_____

Email Address (print legibly if you would like to be on our email list for future activities and events):

_____

Signature:_____

Parent's Signature required if under 18:_____

Please enjoy your time at Saddle Up, but remember fingers look like carrots to horses, it is best to feed all animals with the designated buckets.