STUDENT REGISTRATION FORM

Today's Date: _____

Rider/Participant Name: _____

Date of Birth:_____

Rider/Participant Age: _____

Address:_____

_____

Email:_____ Phone #: (H)_____

(C)_____

Primary Disability:

_____

Secondary
Disability:_____

Date of Onset:_____

DOES THE STUDENT.....

	Yes	**No**
Have speech or language difficulties?	_____	_____
Have a history of seizures?	_____	_____
Have communication difficulties?	_____	_____
Have a fear of animals/horses?	_____	_____

Walk independently? _____ _____

Have a limited range of motion? _____ _____

Have decreased strength/endurance? _____ _____

Have poor balance sitting? _____ _____

Have poor balance standing? _____ _____

Have problems with gross motor skills? _____ _____

Have altered sensation? _____ _____

Have heart/circulation problems? _____ _____

Have allergies or breathing problems? _____ _____

Have digestion/elimination problems? _____ _____

Have bone/joint problems? _____ _____

Have emotional/behavioral problems? _____ _____

Ambulatory? Yes_____ No_____ Crutches _____Cane_____ Braces_____

Walker_____ Wheelchair_____

Previous Riding Experience: Yes_____No _____

If yes, for how long?_____

PHOTO RELEASE

_____ ***I consent*** to and authorize _____ ***I do not consent*** to nor do I authorize the use and reproduction by Making Strides Therapeutic Horsemanship, Inc. of any and all photographs and any other audiovisual materials taken of me or my child for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the program.

I also give consent for my photo to be published on Making Strides Therapeutic Horsemanship, Inc. Facebook page, web site or other digital/social media.

Date:_____

Participant Signature:_____

Signature of Parent/Guardian:_____

Confidentiality Policy

I agree to respect and observe privacy and confidentiality of the participants, volunteers and donors of Making Strides Therapeutic Horsemanship, Inc. and not discuss or disclose any sensitive information about any person or their family.

Date:_____

Participant Signature:_____

Signature of Parent/Guardian:_____

Liability Release

I, _____the Participant/Rider/Volunteer and (if applicable) his/her Parents/Legal Guardians, acknowledge that there are certain significant risks inherent in riding horses and engaging in other equine activities. I assume and accept such risks, including without limitation the risks of death, bodily injury, property damage, falls, kicks bites, collisions and vehicles, horses or stationary objects, fire or explosion, the unavailability of emergency services, or the negligence or deliberate act of another person on the premises; I hereby acknowledge that I am choosing to participate in the Equine Assisted Services and Horseback Riding Program of Making Strides Therapeutic Horsemanship, Inc. I acknowledge the risks, but feel the benefits are greater than the risks. I hereby waive and release for myself, my heirs, executors, administrators, and assigns Making Strides Therapeutic Horsemanship, Inc., Kimberly Childs, Laura Martinelli and all of its riding personnel, its officers, directors, members, volunteers and all other persons regardless of their capacity who are in any way connected with this horseback riding and related activity, and their representatives, heirs, executors, administrators, successors, and assigns and also all persons regardless of their capacity who are in any way connected with Futia Farm, 1644 Albany Post Rd., Wallkill, NY 12589 and their representatives, heirs, executors, administrators, successors, and assigns, from any and all rights, claims, loss, or liabilities of any kind or nature, including costs and attorneys' fees, that I might have in connection therewith, to the maximum extend allowed. Furthermore, I hereby acknowledge that said release will extend to any accidents, damages, or claims arising out of horseback riding caused by my own acts or anyone or any animal within my control.

Date:_____

Signature_____

Print Name_____

Check One: _____Participant_____Volunteer_____Guest

PHYSICIAN ASSESSMENT & HEALTH HISTORY

To be completed by the Physician

Date:_____

Patient Name:_____DOB:_____

Address:_____

City:_____ State:_____ Zip:_____

Height:_____ Weight:_____ Date of Last Tetanus:_____

Primary Diagnosis:_____

Date of Onset:_____

Secondary Diagnosis:_____

Date of Onset:_____

Other:_____

Date of Onset:_____

Past/Prospective Surgeries (Include dates and reasons):

_____
_____
_____

Medications &
Dosage:_____
_____
_____

Seizures: _____ No _____Yes

Type:_____ Date of Last Seizure:_____

For those with Down Syndrome:

An annual complete neurologic exam to exclude Atlantoaxial instability is required for clients with Down syndrome over the age of 3.

Date of Exam:_____

The participant needs to have annual certification from a physician/qualified medical professional that the participants' physical examination reveals no signs of AAI or decrease in neurologic function in order to participate in any mounted activities.

ATTENTION: CONTRAINDICATIONS

PLEASE REVIEW CAREFULLY

In order to safely provide services, Making Strides requests that you please note that the following conditions may suggest precautions and contraindications to equestrian activities. Therefore, please let us know if any of these conditions are present, and to what degree.

Allergies

• Known and severe allergies to animals and an equine environment that could cause a medical emergency.

Atlantoaxial Instability (AII) in down Syndrome

• Children under the age of 2

• Neurologic symptoms of antlantoaxial instability or positive neurologic clinical signs as noted by physician

Mobility Restrictions

• Contractures or spasticity preventing safe positioning on the horse

• Decreased range of motion with pain, stiffness (Coxa arthrosis, Heterotopic Ossification/ Mytositis Ossificans)

• Hip subluxation and Dislocation

• Poor postural alignment in the spine, pelvis and/or lower extremities that cannot be corrected by handling techniques or adaptive tack.

• Joint replacements: Inability to avoid unsafe positions or activies for that individual. • If the participant cannot be safely supported on the horse due to trunk muscle weakness, as in Muscular Dystrophy (MD) /Spinal Muscular Atrophy (SMA).

Head/ Neck Control

• Inability to control for excessive head movement during mounted/ driving activities. • Participant is unable to hold their head against gravity with a helmet on during static sitting. • If use of a helmet causes significant strain to the neck muscles, and impairs head control. • If the participant is positive for alantoaxial instability with or without neurologic signs. (See Atlantoaxial Instability)

Medical Conditions
• Significant or prolonged fatigue or pain following the equine activity that can exacerbate the condition.
• If overexertion heightens the disease progression
• Uncontrolled hypertension
• During periods of exacerbation of neuromuscular disorders such as Multiple Sclerosis • If physical exertion, or the environment, will make breathing more difficult while doing the activity or for any time following.
• Appearance or worsening of neurologic symptoms in conditions such as Spina Bifida, tethered cord, Chiari II Malformation

Extreme Behaviors
• Extreme behaviors that are unsafe and/or unable to be controlled
• Serious alterations in mental status including delirium, dementia, dissociation, psychosis or severe confusion
• Active conditions with behaviors of fire setting, self-abuse, animal abuse, sexual abuse, suicidal thoughts or aggression without
direct support of a mental health professional.

Cranial Defects
• If an ASTM/SEI helmet for equestrian activities cannot offer complete protection to the head.

Diabetes
• Uncontrolled diabetes and/or assoc. medically unstable conditions.

Obesity
• If the staff is unable to safely manage the participant in any situation, including an emergency dismount and is at risk for harming
themselves or the participant.
• If safety or comfort of the equine is compromised during mounted activities potentially resulting in a fight or flight response
which in turn could harm the staff or participant.

Equipment Medical Devices/Casts
• If horse is unable to adapt & rider unable to go without
• Female participants with indwelling catheters

Hemophilia (Hemophilia A/ Hemophilia B/ VonWillebrand Disease
• Severe hemophilia (<1% Factor) and/or a history of bleeding episodes

Osteogenesis Imperfecta (OI)
• Moderate to severe OI with recent fractures, significant scoliosis or poor head/ trunk control.

Osteoporosis
• Moderate to severe osteoporosis
• A history of fractures
• Pain with activity, particularly of the spine

Pathologic Fractures
• Recurrent pathologic fractures without successful treatment of the underlying medical cause.

Peripheral Vascular Disease (PVD)
• If skin damage is present, particularly in a weight bearing area.
• Redness, swelling or pain persists > 15 to 20 minutes after mounted activities and accommodation cannot be made.

Seizure Disorders/ Epilepsy
• Recent seizure activity accompanied by strong, incontrollable motor activity or atonic or "drop attack" seizures due to their sudden and complete loss of postural muscle tone.
• A change of frequency or type of seizure until the condition is evaluated.
• Inability to manage a participant during an emergency dismount should a seizure occur.

Skin Breakdown
• Open skin areas on a weight bearing surface or on a surface that may be subject to friction (buttocks, inner thighs, calves,
hands, etc.)
• Recent skin graft over an area of weight bearing or friction. A release from physician is required to resume mounted
activities.

Spinal Cord Injury (SCI)
• Complete spinal cord injury above T-6 without adaptive tack that can assist in stabilization without interference to the
movement of the equine and with quick release hardware.

Spinal Curvature
• If the activity produces lasting pain.
• If there is not enough spinal mobility to accommodate to the movement of the equine.
• If the spinal curvature is getting worse over time.
• Aggravation to compromised pulmonary function, heart function, circulation, and/or skin breakdown.
• Moderate or severe scoliosis or inability to achieve a full upright posture.

Spinal Fusion/ Fixation
• If there is insufficient mobility in the spinal joints above and below the fixation/ fusion to accommodate the movement of the
equine.
• If there is pre-existing condition of severe degenerative joint disease in the remaining mobile spinal joints.
• If there is significant pain.
• If physician has not released participant for post surgical participation, indicating a solid bony fusion/ fixation.

Spinal Orthosis
• Use of a rigid chin support attached to the spinal orthosis

Substance Abuse/ Drug or Alcohol Dependence
• Active substance abuse.

Surgical Procedures- Recent- pending release for equine activity

PHYSICIAN ASSESSMENT & HEALTH HISTORY (PART 2)

To be completed by the Physician

Patient 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/Comment
Auditory			
Visual			
Speech			
Tactile/Sensory			
Cardiac			
Circulatory			
Pulmonary			
Integumentary/Skin			
Immunity/HIV			
Neurologic			
Muscular			
Orthopedic			
Bowel/Bladder			
Learning Disabilities			
Cognitive			
Emotional/Psychological			
Behavior			
Other_____			G

Given the above diagnosis and medical information, this person is not medically precluded from participation in supervised equestrian activities. I understand that Making Strides Therapeutic Horsemanship, Inc. 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 Making Strides for evaluation to determine eligibility for participation with ongoing treatment as described in therapy evaluation.

Date of Exam:_____

Name: _____MD, DO, NP, PA, Other

Signature:

_____Date:_____

Address: _____

Phone: _____ License:_____

EMERGENCY CONTACT INFORMATION

Rider/Participant Name:_____ Age:_____

Address: _____

City_____State:_____Zip:_____

Home Phone:_____ Mobile Phone:_____

Email:_____

In the event of an emergency please contact:

1. Name_____Telephone:_____

2.Name:_____ Telephone:_____

3.Name:_____ Telephone:_____

Doctor's Name:_____ Doctor's Phone:_____

Preferred Medical Facility:_____

Health Care Insurance Company: _____

Policy #:_____ Tetanus Shot: ___Y ____N Date:_____

Allergies:_____

Antidote needed: _____Y _____N Antidote carried: _____Y_____ N

Protocol for Emergency Treatment:_____

Current Medications:_____

Please describe any medical condition requiring special precautions or treatment including HIV:

_____