EquiFriends

Rider Registration Forms
Non-Profit 501 (c) (3) organization | Tax ID # 91-1455100

EMERGENCY MEDICAL RELEASE FORM

Rider's Name: _____Phone: _____

Parent/Guardian:_____Phone: _____

Address: _____

City: _____Zip: _____ County: _____

Rider's Disability: _____Date of Onset:_____

Physician's Name: _____Phone: _____

Address: _____

Person who is authorized to give temporary assistance or care in absence of parent or guardian:

Name: _____ Phone: _____ Relationship: _____

Preferred Medical Facility: _____

Describe any medical condition requiring special precautions or treatment and any medications and dosage:

(A) None: _____ (B) Please describe: _____

In case of medical emergency, the undersigned authorizes _____ to provide medical assistance as they determine necessary.

The undersigned authorizes any licensed physician and/or hospitalization for the rider, including anesthetic, which they determine necessary or advisable, pending receipt of a special consent form from the undersigned.

No person can be accepted for riding instruction until this form has been completed by the parent or guardian. If the person is of legal age (18), he/she may complete the form, if he/she is legally competent to do so. Riding instruction will be under strict supervision, and although every effort will be made to avoid any accident, NO LIABILITY can be accepted by any of the organizations concerned, including EquiFriends and Les Chevaux.

Yes, I would like _____to have riding instruction and I have discussed this with the rider's doctor. I understand that NO LIABILITY can be accepted by any organization concerned with this instruction, including Les Chevaux in the event of any accident which may occur.

I HAVE READ THIS ENTIRE RELEASE AND AGREE TO IT.

Signature: _____Date: _____

Signature: _____Date: _____
(Parent or Guardian must sign if participant under 18 years)

Return completed forms to
EquiFriends, PO Box 856, Snohomish, WA 98291

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RIDER/PARENT/GUARDIAN/CUSTODIAN RELEASE & INDEMNITY AGREEMENT FOR RIDING AND DRIVING INSTRUCTIONS

The undersigned, individually, and/or as parent, custodian and/or guardian of _____ _____ (Rider), a minor (or other incompetent), for and in consideration of the agreement of EquiFriends, a non-profit corporation, to provide riding and/or driving instructions to said Rider, does/do hereby assume all risks and forever releases, acquits, discharges and holds harmless EquiFriends, a non-profit corporation, its directors, officers, trustees, agents, employees, instructors, volunteers, donors, bailors, representatives, successors and assigns and lessors (releasees/indemnitees), for all manner of claims for damages of every kind and nature whatsoever, which the undersigned or said Rider may now, or in the future have against the releasees/indemnitees on account of death or bodily injury or personal injury, physical or mental condition, property damage, known or unknown to the person of the undersigned or Rider and the treatment therefore, or in anyway arising out of accidents, occurrences or conditions whether or not caused by the negligent or gross negligent acts of the releasees/indemnitees; and the undersigned,

Further agrees to defend all claims and suits and indemnify the releasees/indemnitees against all liability claims for bodily injury, personal injury, death, mental or physical condition or property damage sustained by any person, including the undersigned Rider or any releasees/ indemnitees, caused or alleged to have been caused directly or indirectly by any act, omission, accident, occurrence, condition, negligence or gross negligence of the undersigned, Rider or any releasees/ indemnitees arising out of the riding or driving instructions, including the related activities with the Rider's assigned horse such as grooming, saddling and harnessing.

Signed: _____ Date: _____

Rider/Parent/Guardian/Custodian: _____

Parent/Guardian/Custodian: _____

Address: _____

Phone: _____

Witness: _____

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PHOTO RELEASE FORM

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grant to EquiFriends/ Les Chevaux permission to take or have taken, still and moving photographs and films including television pictures of _____ and consents and authorizes EquiFriends/Les Chevaux , its advertising agencies, news media, and any other persons interested in EquiFriends/Les Chevaux, and its work, to the use and reproduction of the photographs, films, and pictures to circulate and publicize the same by all means including without limit, the generality of the foregoing newspapers, television media, brochures, pamphlets, instructional materials, books and clinical material.

With regard to the foregoing material, no inducements or promises have been made to us/me to secure our/my signature(s) to this release other than the intention of EquiFriends/Les Chevaux to use or be used such photographs, films and pictures for the primary purpose of promoting and aiding its program and its work.

Dated this _____ day of _____ , 2_____

Signed: _____

Return completed forms to
EquiFriends, PO Box 856, Snohomish, WA 98291

THERAPIST'S ASSESSMENT

Name: _____ Birth Date: _____

Disability: _____

_____

School, Center, or Organization: _____

_____

Evaluation Summary: _____

_____

Special Communication Requirements: _____

_____

Suggested Mounting Procedures: _____

_____

Suggested Exercises: _____

_____

_____

Precautions and/or Contraindications: _____

_____

_____

_____

Signed: _____ Title: _____

Please Print Name: _____

Date: _____ Phone Number: _____

PHYSICIAN'S REFERRAL FORM (Page 1 of 4)

Name: _____ Date of Birth:_____

Address: _____ City:_____ Zip: _____

Parent/Legal Guardian(s): _____Phone:_____

Diagnosis: _____ Date of Onset: _____

Medical History (include Surgeries and Dates): _____

_____

_____

Medications: _____

IF DIAGNOSIS IS DOWN'S SYNDROME, THIS FORM MUST BE ACCOMPANIED BY ONE OF THE FOLLOWING:

A) Washington State Special Olympics Down's Syndrome Athletic Evaluation, or

B) A signed, dated statement from a qualified physician giving the date and results of a diagnostic X-ray for Atlantoaxial Dislocation Condition

Height:_____ Weight:_____ **(over 180 lbs must have prior authorization)**

Please check off yes or no for each of the following conditions. Presence of each condition may or may not be appropriate to receive riding instruction. Further information may be necessary.

YES NO CONDITION

___ ___ Spinal Fusion - If yes, which vertebrae: _____

___ ___ Spinal Instability/Abnormalities - If yes, which vertebrae: _____

___ ___ Scoliosis - If yes, Explain/Describe: _____

___ ___ Kyphosis (Excessive or Abnormal)

___ ___ Lordosis (Excessive or Abnormal)

___ ___ Hip Subluxation and/or Dislocation - If yes, describe: _____

PHYSICIAN'S REFERRAL FORM (Page 2 of 4)

Name: _____ Diagnosis: _____

YES NO CONDITION

___ ___ Osteoporosis

___ ___ Pathologic Fractures: Mild _____ Moderate _____ Severe _____

___ ___ Coxa Arthorsis

___ ___ Heterotopic Ossification

___ ___ Spinal Orthoses

___ ___ Internal Spinal Stabilization Devises - Type: _____

___ ___ Hydrocephalus with Shunt

___ ___ Spina Bifida - Type and Level: _____

___ ___ Tethered Cord

___ ___ Chiari II Malformation

___ ___ Hydromyelia

___ ___ Paralysis

___ ___ Cranial Deficits

___ ___ Cerebral Palsy - Type: _____

___ ___ Gastostomy Tube - Type: _____

___ ___ Seizures - Type: _____

___ ___ Controlled with medication

___ ___ Allergies - Type: _____

___ ___ Diabetes - Type: _____

___ ___ Peripheral Vascular Disease - Type: _____

___ ___ Varicose Veins

___ ___ Poor Endurance

___ ___ Hemophilia

PHYSICIAN'S REFERRAL FORM (Page 3 of 4)

Name: _____ Diagnosis: _____

YES NO CONDITION

___ ___ Hypertension

___ ___ Controlled with medication

___ ___ Heart Condition - Type:_____

___ ___ Cerebrovascular accident (Stroke)

___ ___ Aneurysm

___ ___ Known embolus

___ ___ Known thrombus

Psychological (include IQ if pertinent): _____

_____

Incontinence: _____Postural Muscle Tone: _____

Visual Defects: _____Auditory Defects: _____

Speech: _____Defects:Circulation: _____

Neuro-Sensation: _____Coordination: _____

Spasticity and/or Rigidity: _____Contractures: _____

Braces: _____Assistive Devices: _____

General Comments: _____

_____

_____

PHYSICIAN'S REFERRAL FORM (Page 4 of 4)

Name: _____ Diagnosis: _____

PLEASE CHECK ONE OF THE FOLLOWING:

___ *In my opinion, this patient can receive RIDING instruction under appropriate supervision.*

___ *In my opinion, this patient can receive HORSE DRIVING instruction under appropriate supervision.*

Physician's Signature: _____ Date: _____

Physician's Name (please print or type): _____

Address: _____City:_____ Zip:_____

Phone: _____

******Medical Forms Must Be Dated, and Updated Yearly******

LES CHAVAUX RELEASE FORM

Whereas, 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/or working, around horses at Les Chevaux Farm, the undersigned does hereby agree to hold harmless and indemnify Les Chevaux Farm and/or Steve and Jennifer Gibson and further release them from any liability or responsibility for accident, damage, injury, 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 Les Chevaux Farm.

Signature: _____

Print Name: _____

Date: _____