RIDER/CONTACT INFORMATION SHEET

Rider's Information

Student's Name ________________________________

Date of Birth _____ Gender: M F Weight____________

Current Diagnosis :____

Current Treatment/Services :____

Street address____

City________________________ State_____ Zip Code_______________________

E-mail____

Rider is a (circle one): minor adult w/a legal guardian independent adult

Parent/Guardian Name_________________________ Cell Number_____________

Occupation_____________________________ Work Number________________

Other Parent/Guardian Name___________________ Cell Number_____________

Occupation _____________________________Work Number________________

Contact Information (used for scheduling, billing, newsletters etc.)

Person in charge of rider's schedule/billing________________________________

Relationship to rider _______________ Preferred phone number________________

Billing Address (if different from above)___________________________________

City__________________________ State_____ Zip Code_____________________

Primary email ____

As a non-profit organization, we strive to keep our lesson fees reasonable. They cover 25% of the cost of the lessons. We rely heavily on a volunteer base to keep our program running. Is there any way you would be willing to help RAY OF SUNSHINE Equestrian Therapy?

____

Questionnaire & Health History

Ray of Sunshine Equestrian Therapy is not equipped to handle those who are not physically able to get on a horse. All students must be able bodied. All students in treatment must be cleared by their doctor in order to participate the riding portion of the program.

Has the student had previous experience with therapeutic riding? YES NO
If yes, please explain…

____

____

Goals: What are you hoping to accomplish by participating at Ray of Sunshine Equestrian Therapy?

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____

____

Comments: please give any info that you feel will be helpful in lesson planning:

____

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____

PHYSICIAN'S REFERRAL FORM

To be signed and dated by current Doctor

Patient's Name:____

Parent Name and Contact # ____

Patient's date of birth:______ Height:_____ Weight: ________

Medical History

Diagnosis: ___________

Other Concerns: ____

Present Medications: ____

Physical Evaluation

Heart/Lungs Balance/Coordination

Vision/ Hearing :____________________

Other :_______________________________

Precautions/Contraindications to Therapeutic Horseback Riding:

____

In my opinion, this patient is able to receive therapeutic horseback riding instruction under appropriate supervision at Ray of Sunshine Equestrian Therapy

Physician's Signature Date ;__________________________________

Physician's Name Phone ____________________________________

Office Address :____

Parent/Guardian Signature Date;___________________________________

RELEASE OF LIABILITY AGREEMENT

Name of Rider :______________________

Name of Parent or Guardian:_______________________

Address City & Zip:___________________________

Telephone Number :__________________________

Emergency Contact :_________________________

RAY OF SUNSHINE EQUESTRAIN THERAPY Program is a professionally orientated and controlled. All staff, volunteers, and horses have been carefully selected. Safety equipment is used for all riders because horseback riding is a risk exercise.

No student can be accepted in to the RAY OF SUNSHINE EQUESTRAIN THERAPY program until a parent or guardian has signed this form or, if the rider is of legal age he or she may sign. Therapeutic riding instruction will be under strict supervision and although every effort will be made to avoid any accident, NO LIABILTY can be accepted by the organization or any persons connected with the organization.

The undersigned as self or parent/guardian of said minor _________________, hereby agrees to hold harmless and indemnify RAY OF SUNSHINE Equestrian Thearpy, its officers, trustees, agents, employees, volunteers, representatives, and successors from all manner of liability, loss, costs, claims, demands and damages of any kind and nature whatsoever, which the undersigned may now or in the future have against the said facility.

Date ________________________

Signed ___________________

Hanson Quarter Horses

4571 S. Mission
Fallbrook, CA 92028

HOLD HARMLESS RELEASE

THIS RELEASE CONTAINS IMPORTANT LIMITATIONS OF YOUR LEGAL RIGHTS, READ AND UNDERSTAND BEFORE SIGNING. IF YOU HAVE ANY QUESTIONS, ASK FOR AN EXPLANATION.

I acknowledge that competitive and pleasure horse riding contains inherent risks of injury and damage to me personally, to my horse, and to my equipment. Knowing these facts, I nevertheless, in consideration to your acceptance of this form, hereby, for myself, my heirs, my guests, and administrators, waive, release, and discharge and hold harmless HANSON QUARTER HORSES, Cathy Hanson, Cherie Vonada and all persons and organizations in any way connected with the events, property, boarding, training, lessons, transporting or any other activity described herein, their representatives, heirs, executers, administrators and assignees from any and all right, claim or liability for damages or for any and all claims of any kind or nature that I might have as a result of, or arising out of my participation, caused by my own act or the acts of anyone or any animal within my control or the control of HANSON QUARTER HORSES, Cathy Hanson, Cherie Vonada and all other persons and organizations connected in anyway. I further agree that I will defend, indemnify and hold harmless HANSON QUARTER HORSES, Cathy Hanson, Cherie Vonada, their agents, employees and all others connected against all claims, demands and causes of action including court costs and attorney's fees directly or indirectly arising from any action or other proceeding brought by or prosecuted for my benefit contrary to this release extended to all claims of every kind and nature whatsoever whether known or unknown and expressly waive any benefits I may have under Section 1542 of the California Civic Code.

I DO ACKNOWLEDGE I HAVE READ THE FORGOING PARAGRAPH AND KNOW AND UNDERSTAND THE CONTENT THEREOF.

_______________________________________ _______________________________________
Signature Printed Name

_______________________________________ _______________________________________
Home Phone Cell Phone

_______________________________________ _______________________________________
Emergency Contact Name Emergency Contact Phone Number

I declare that the foregoing is true and correct.

Executed this ___________ day of ________________________________, 20______

AUTHORIZATION FOR MEDICAL TREATMENT

Name of Rider:_______________________________________
Name of Parent: ______________________________________
Rider's Date of Birth: __________________________________
Current Diagnosis:____________________________________
Current Medications:__________________________________
Allergies to Food/ Medications: ____________________________
Date of Last Tetanus Shot:________________________________
Any special Instructions: ________________________________

In the event that emergency medical treatment is required due to an illness or injury during a therapeutic riding session, I authorize RAY OF SUNSHINE EQUESTRAIN THERAPY to:
1. Call emergency medical help and consent to any necessary treatment that may include transportation, x-ray examination, surgery, medication, or hospitalization.
2. Release student records upon request of authorized emergency medical personnel if needed.

It is understood that every effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Consent Signature Date:________________________________
Print Name and Relationship:____________________________
Telephone numbers where parents can be reached:
Mother :____

Father:____

Gaurdian____

PHOTO RELEASE FORM

The undersigned hereby grants RAY OF SUNSHINE EQUESTRAIN THERAPY permission to take or have taken still or moving photographs of myself/ daughter/ son _________________. The undersigned also authorizes RAY OF SUNSHINE EQUESTRAIN THERAPY to use such photographs in its advertising, news media, brochures, pamphlets, and instructional material.

Date :____

Signed :____

RESEARCH DATA RELEASE FORM

The undersigned hereby grants permission to use all test results and scores obtained from evaluations, both formal and informal of ________ while said person is in attendance at RAY OF SUNSHINE EQUESTRAIN THERAPY. Aforesaid material will be used for the purpose of research and conducted by RAY OF SUNSHINE EQUESTRAIN THERAPY and RAY OF SUNSHINE EQUESTRAIN THERAPY staff or consultants. No use of this data will be included in published material.

Date :_____________________________________

Signed:___________________________________