Fredericksburg, VA

Foundation Office (540) 898-8219

Stable Office (540) 891-7101



hazel wild trpriding @gmail.com

Hazelwild Farm Therapeutic Riding Program Registration and Release Form

Rider's Name:		Date of E	Birth:	/ / Ag	ge:	_ M or F
Weight:	Height:	Disabilit	zy:			
Parent/Guardian Name:			Cell P	Phone: ()		
Street Address:			Home	Phone: ()		
City:		State:		Zip: _		
Email Address:						
Business Name:			Busin	ess Phone: ()	
Address:	City:			State:	Zip:	
Emergency Contact:		Phone: ()	Cell:	()	
School or Institution presently at	tending:					
Phone: ()	Teacher's	Name:				
PHOTO RELEASE:	I hereby consent	to and authori	ize			
——— I d	lo not consent to	and authorize				

The use and reproduction by Hazelwild's Therapeutic Riding Program of any and all photographs and other audio-visual materials taken of me/my child for promotional printed material, educational activities, exhibitions or any other use for the benefit of the program.

What other activities are of interest to you other than riding?

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Signature:(If participant is a minor, parent/guard	dian signature is required)	Date:	
RIDEI It is helpful for the staff to know of your interest for you. Please complete the following question	~ -	scheduling and developing	a program
Name:	Age:	Date:	
What interests you in Hazelwild's Therapeutic R	Riding Program?		
What are your goals for the riding sessions? (i.e paying attention, etc.) Please be specific.	e.,Riding skills, behavio	oral changes, physical impr	ovements,
Please describe any previous horseback riding ex	xperience.		

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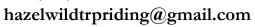
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How did you hear about our program?			
	ABILITY DESCRIPTION ase answer where pertinent)		
Name:	Age:	Date:	
Disability:			
Posture:			
Balance:			
Movement Coordination:			
Behavior:			
Attitude:			
Perceptual Problems:			
Communication Problems:			
Mental Ability:			

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Precautions and/or Restriction	s:	
Suggestions:		
Signature:	Title:	Date:
CON	NSENT FOR RELEASE OF INFORMAT	TION
I hereby authorize		
·	(Person or Facility)	
to release information from the r	ecords of	
	(Client's Name)	
Date of Birth:		
The information is to be released information to be released is man	to Hazelwild's Therapeutic Riding Progranked below.	n for the above named student. The
YES		
Medical History		
Physical Therapy	evaluation, assessment and program plan	
Occupational The	rapy evaluation, assessment and program pla	an
Speech Therapy e	valuation, assessment and program plan	
Classroom Individ	dual Education Plan (I.E.P.)	
Other:		

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Signature:	Date:	_
(Client, Parent or Guardian)		
Please send material to:		
Hazelwild Farm Therapeutic Riding		
5325 Harrison Road		
Fredericksburg, Virginia 22407		
MEDICAL HISTOR	RY / RELEASE	
Name:	Date of Birth:	
Address:		
Disability/Diagnosis:		
Height:	Weight:	
Name of Parent/Guardian:		
Tetanus Shot: () No () Yes Date:		
Seizure Type: Controlled:	Date of Last Seizure:	
Medications:		_
Allergies:		
**** FOR PERSONS WITH	DOWNS SYNDROME ****	
Cervical x-ray for Atlanto-Axial Instability:		
() Positive () Negative X-ray Date:		

Please indicate if patient has a problem in any of the following areas by checking yes or no. If yes, please comment, using the back of the paper if necessary.

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Area	Yes	No	Con	nme	ents					
Auditory										
Visual										
Speech										
Cardiac										
Circulatory										
Pulmonary										
Neurological										
Muscular										
Orthopedic										
Ar	<u>rea</u>		Y	<u>'es</u>	<u>No</u>		Commer	<u>its</u>		
Allergies										
Learning Disa	ability									
Mental Impai	rment									
Psychologica	l Impa	irmen	t							
Surgery										
Other										
Independent An		ion: ces:			es Ses	MOBILITY) No) No	Crutches: Wheelchair:) Yes) Yes) No) No
Please indicate	anv sn	ecial i	nreca	utio	ng:					

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In my opinion, this patient can participate in s activities, I concur in the referral of the patien limitations in performing exercises and imples	at to a physical or occupationa	l therapist for evaluat	
Physician	n's Signature:		-
	Date:		
Physician's Name (please print):			
Address:		Zip:	
Phone: ()			
INITIAL PSYCHOSOCIAL EVALUATION Name of Patient: SUMMARY OF PRESENTING PROBLEM	Age: _	Date:	
PSYCHOSOCIAL HISTORY:			
MEDICATIONS/ALLERGIES:			

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DIAGNOSIS (DSM-IV-R):		
Axis I: Axis I Axis III: Axis V:	I: Axis IV:	
Current GAF – GOALS:		
OTHER COMMENTS:		
Please attach additional information.		
Signature of Treatment Coordinator/Therapist:		
Printed Name:	I	Date:
Address:		
Phone: (
It is helpful for the staff to know of your interests and avail for you. Please complete the following questions.	ability prior to sch	eduling and developing a program
Name:	Age:	Date:
General Information (brief history and muscle evaluation)	:	
	_	
Joint Evaluation:		

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Behavior:		
Functional Ability and Limitation Imposed by Reflexes:		
Capable of Independent Sitting with Support? (Physical Therapy Program:) Yes	() No
Goals:		
Primary Physical Therapist's Signature:		
Printed Name:		Date:
Address:		
City:	State:	Zip:
Phone: (Phone: () -

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FOR RIDERS

In the event emergency medical aid/treatment is required due to illness or injury while being on the property of the Hazelwild Farm, I authorize HAZELWILD to:

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

In case of Emergency, contact	Phone	
<i>U</i> 3,		

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Or		Phone	
Physician's Name	Town	Phone	
Preferred Medical Facility			
Health Insurance Carrier		Policy #	
Medical conditions and/or medical	dications we should know a	bout:	
Allergies			
Date of last Tetanus shot			
for emergency medical treatm	nent/aid (including x-ray, s	Emergency contact cannot be reached) I give ourgery, hospitalization, medication and any tree event of illness or injury while on the prop	eatment
Date	Consent Signature		
	(Parent o	r Guardian if volunteer is under 16 years of age)
<u>NON-CONSENT PLAN</u> – I	do not give consent for em	nergency treatment/aid in the event of illness or	r injury
while on the property of Haze	lwild Farm. In the event em	nergency treatment/aid is required, I wish the following	llowing
procedures to take place:			
DateNon-c	onsent Signature		
	(Parent o	r Guardian if volunteer is under 16 years of age))

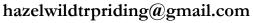
ATTENDANCE

1. Hazelwild expects regular attendance by all clients. We will not offer a makeup week so please make sure we get to see you each week. *Refunds are not given for missed lessons.*

Fredericksburg, VA

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- 2. Clients who expect to be absent must notify Connor via email (hazelwildtrpriding@gmail.com) at least 24 hours prior to the scheduled lesson time. Two absences without notification, and more than two absences with or without notice may result in a client being placed on a waiting list.
- 3. The Hazelwild class schedule is subject to change. In the event of unforeseen circumstances, all reasonable attempts will be made to notify clients at least 2 hours prior to a schedule change. In the event Hazelwild must cancel a lesson. We will reschedule it at the end of the season.

PAYMENT

- 1. The fee is \$30 per lesson. The fees for each full session are due prior to the first day of class. Cash payments will no longer be accepted. Please plan to pay with a check.
- 2. A \$20 registration fee is required of all clients for each session. This is a non-refundable fee that helps defray the cost of processing the paperwork. This fee must accompany the lesson fees at the beginning of each session.



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