**5325 Harrison Road · Fredericksburg, VA 22407**
**Foundation Office** **Stable Office**
**(540) 898-8219** **(540) 891-7101**
**hazelwildtrpriding@gmail.com**

**Hazelwild Farm Therapeutic Riding Program**

**Registration and Release Form**

Rider's Name: ______________________ Date of Birth: ___/___/___ Age: ______ M or F

Weight: __________ Height: ________ Disability: ______________________

Parent/Guardian Name: ______________________ Cell Phone: (____) __________

Street Address: ______________________ Home Phone: (____) __________

City: ______________________ State: __________ Zip: __________

Email Address: ____________________________________________

Business Name: ______________________ Business Phone: (____) __________

Address: ______________ City: ______________ State: _____ Zip: _____

Emergency Contact: ______________ Phone: (____) ________ Cell: (____) ________

School or Institution presently attending: ______________________

Phone: (____) ______________ Teacher's Name: ______________________

**PHOTO RELEASE:** ______ I hereby consent to and authorize …

______ I do 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.

Signature: ______________________________ Date: ______________

(If participant is a minor, parent/guardian signature is required)

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HazelWild Therapeutic Riding

## RIDER QUESTIONNAIRE

It is helpful for the staff to know of your interests and availability prior to scheduling and developing a program for you. Please complete the following questions.

Name: ______________________________ Age: __________ Date: ______________

What interests you in Hazelwild's Therapeutic Riding Program?

_______________________________________________

_______________________________________________

What are your goals for the riding sessions? (i.e., …Riding skills, behavioral changes, physical improvements, paying attention, etc.) Please be specific.

_______________________________________________

_______________________________________________

Please describe any previous horseback riding experience.

_______________________________________________

_______________________________________________

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

_______________________________________________

_______________________________________________

How did you hear about our program?

_______________________________________________

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## DISABILITY DESCRIPTION

(Please answer where pertinent)

**Name:** ______________________________ **Age:** __________ **Date**: ______________

**Disability:** ____________________________________________

**Posture:** ____________________________________________

____________________________________________

**Balance:** ____________________________________________

____________________________________________

**Movement Coordination:** ____________________________________________

____________________________________________

**Behavior:** ____________________________________________

____________________________________________

**Attitude:** ____________________________________________

____________________________________________

**Perceptual Problems:** ____________________________________________

____________________________________________

**Communication Problems:** ____________________________________________

____________________________________________

**Mental Ability:** ____________________________________________

____________________________________________

**Precautions and/or Restrictions:** ____________________________________________

____________________________________________

**Suggestions:** ____________________________________________

____________________________________________

**Signature:** ______________________ **Title:** ________________ **Date:** __________

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## CONSENT FOR RELEASE OF INFORMATION

I hereby authorize ______________________________________________
(Person or Facility)

to release information from the records of ____________________________
(Client's Name)

Date of Birth: ________________

The information is to be released to Hazelwild's Therapeutic Riding Program for the above named student. The information to be released is marked below.

***YES***

______ Medical History

______ Physical Therapy evaluation, assessment and program plan

______ Occupational Therapy evaluation, assessment and program plan

______ Speech Therapy evaluation, assessment and program plan

______ Classroom Individual Education Plan (I.E.P.)

______ Other: ____________________________________________

Signature: ______________________________ Date: ______________
(Client, Parent or Guardian)

Please send material to:

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**MEDICAL HISTORY / RELEASE**

Name: ______________________________ Date of Birth: ____________________

Address: ________________________________________________

Disability/Diagnosis: ______________________ Date of Onset: ____________________

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.

| ***Area*** | **Yes** | **No** | **Comments** |
|---|---|---|---|
| Auditory | | | |
| Visual | | | |
| Speech | | | |
| Cardiac | | | |
| Circulatory | | | |
| Pulmonary | | | |
| Neurological | | | |

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| | | | |
|---|---|---|---|
| Muscular | | | |
| Orthopedic | | | |

| **Area** | **Yes** | **No** | **Comments** |
|---|---|---|---|
| Allergies | | | |
| Learning Disability | | | |
| Mental Impairment | | | |
| Psychological Impairment | | | |
| Surgery | | | |
| Other | | | |

**MOBILITY**

Independent Ambulation: ( ) Yes ( ) No Crutches: ( ) Yes ( ) No

Braces: ( ) Yes ( ) No Wheelchair: ( ) Yes ( ) No

Please indicate any special precautions:

______________________________________________________________________

______________________________________________________________________

In my opinion, this patient can participate in supervised equestrian activities. In conjunction with these activities, I concur in the referral of the patient to a physical or occupational therapist for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program.

Physician's Signature: ______________________________

Date: ___________________

Physician's Name (please print): ______________________________________________

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Address: ______________________________________________

City: ______________________________ State: __________ Zip: __________

Phone: (____) ____________________ Fax: (____) ____________________

## INITIAL PSYCHOSOCIAL EVALUATION

Name of Patient: ______________________________ Age: ____ Date: ____________

**SUMMARY OF PRESENTING PROBLEMS:**

______________________________________________

______________________________________________

**PSYCHOSOCIAL HISTORY:**

______________________________________________

______________________________________________

**MEDICATIONS/ALLERGIES:**

______________________________________________

______________________________________________

**DIAGNOSIS (DSM-IV-R):**

Axis I: Axis II:
Axis III: Axis IV:
Axis V:

Current GAF – **GOALS:**

______________________________________________

______________________________________________

**OTHER COMMENTS:**

______________________________________________

______________________________________________

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**Please attach additional information.**

Signature of Treatment Coordinator/Therapist: ______________________

Printed Name: ______________________ Date: ______________

Address: ______________________

Phone: (____) ______ - ______ Fax: (____) ______ - ______

**PRIMARY PHYSICAL THERAPIST – PHYSICAL THERAPY EVALUATION**

It is helpful for the staff to know of your interests and availability prior to scheduling and developing a program for you. Please complete the following questions.

Name: ______________________ Age: Date: ______________

General Information (brief history and muscle evaluation): ______________________

______________________

______________________

Joint Evaluation: ______________________

______________________

______________________

Behavior: ______________________

______________________

Functional Ability and Limitation Imposed by Reflexes: ______________________

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______________________________ ______________

Capable of Independent Sitting with Support? ( ) Yes ( ) No

Physical Therapy Program: ______________________________

______________________________

______________________________

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 ______________

Or ______________________ Phone ______________

Physician's Name ______________ Town ______________ Phone ______________

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Preferred Medical Facility ____________________

Health Insurance Carrier ____________________ Policy # ____________________

Medical conditions and/or medications we should know about: ____________________

____________________

Allergies ____________________ Other ____________________

Date of last Tetanus shot ____________________

**CONSENT PLAN** (To be invoked in the event that you Emergency contact cannot be reached) I give consent for emergency medical treatment/aid (including x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician) in the event of illness or injury while on the property of Hazelwild Farm.

Date ____________ Consent Signature ____________________
(Parent or Guardian if volunteer is under 16 years of age)

**NON-CONSENT PLAN** – I do not give consent for emergency treatment/aid in the event of illness or injury while on the property of Hazelwild Farm. In the event emergency treatment/aid is required, I wish the following procedures to take place:

____________________

Date ____________ Non-consent Signature ____________________
(Parent or 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.***

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.

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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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