5325 Harrison Road
Fredericksburg, VA 22407
HazelwildTRP@gmail.com

Hazelwild Farm Therapeutic Riding Program
Registration and Release Form

Thank you for your interest in Hazelwild Farm's Therapeutic Riding Program. Our lesson times are on Tuesday evenings at 5:00, 6:00, and 7:00. The riding ring is outside so we are weather dependent – that means we may cancel a week here or there due to thunderstorms and we take a short break in the hottest part of Summer and the coldest part of Winter. Please take a moment to review our Attendance and Payment policies on page 3. If you have any questions about any part of this form, please contact HazelwildTRP@gmail.com.

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: _____

RIDER QUESTIONAIRE

Name: _____ Age: _____ Date: _____

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.

_____

_____

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DISABILITY DESCRIPTION

(Please answer where pertinent)

Name: _____ **Age:** _____ **Date**: _____

Disability: _____

Posture and Balance: _____

_____

Movement Coordination: _____

_____

Behavior and Attitude: _____

_____

Perceptual Problems: _____

_____

Communication Problems: _____

_____

Mental Ability: _____

_____

Precautions and/or Restrictions: _____

_____

Suggestions: _____

_____

Signature: _____ **Date:** _____

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ATTENDANCE & PAYMENT

We offer multiple six-week long sessions throughout the year. The cost for each six-week session is $165. Payment is due the first day of class. A payment plan is available if needed, whereby 50% is payable prior to the first class, and 50% is payable mid-session (week 3 of a 6-week session). Following each six-week session there will be one make-up lesson for anyone with a notified absence. Riders who miss more than one session are still expected to pay $165. Riders who were able to make all six lessons may also participate in this make-up lesson for a fee of $25.

Hazelwild expects regular attendance by all riders. Riders who expect to be absent must notify Kristie and/or Rebecca via email, or telephone at least 24 hours prior to the scheduled lesson time. If an unforeseen illness or emergency arises the day of lessons, riders are expected to notify Kristie and/or Rebecca as soon as possible. Multiple absences without notification may result in a rider being removed from the program.

The riding ring is outside, so we are weather dependent. In the event lessons must be cancelled due to inclement weather, all reasonable attempts will be made to notify riders at least 2 hours prior.

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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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 _____

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)

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

YES

_____ Medical History / Release (Required)

_____ Physical Therapy Evaluation (Optional)

_____ Other: _____

Signature: _____ Date: _____
(Client, Parent or Guardian)

Please send material to:

Hazelwild Farm Therapeutic Riding
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MEDICAL HISTORY / RELEASE (REQUIRED)

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			
Muscular			
Orthopedic			

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(Medical History / Release continued)

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.

Physician's Signature: _____

Date: _____

Physician's Name (please print): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____

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PHYSICAL THERAPY EVALUATION (OPTIONAL)

Name: _____ Age: _____ Date: _____

General Information (brief history and muscle evaluation): _____

_____

_____

Joint Evaluation: _____

_____

Behavior: _____

_____

Functional Ability and Limitation Imposed by Reflexes: _____

_____

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

Physical Therapy Program: _____

_____

_____

Goals: _____

In my opinion, this patient can participate in supervised equestrian activities.

Primary Physical Therapist's Signature: _____

Date: _____

Primary Physical Therapist's Name (please print): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____