



# SUNRISE EQUITHERAPY

## Registration, Liability Release and Photo Release

### Registration

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Parents or Guardian (Client Only): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Parents or Guardian Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of school or institution presently attending (Client Only): \_\_\_\_\_

In case of emergency contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

In case of emergency contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

***Sunrise EquiTherapy, Inc. reserves the right to dismiss any client/rider at any time with or without cause at the sole digression of the Program Director.***

\_\_\_\_\_ (Client) would like to participate in Sunrise EquiTherapy, Inc. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself / my son / my daughter / my ward are greater that the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Board of Regents University of Nebraska, Gail Jensen, Matt Kleinschmit Sunrise EquiTherapy, Inc., its Board of Directors, Instructors, Therapists, Aids, Volunteers and / or Employees for any and all injuries and / or losses I / my son / my Daughter / my ward may sustain while participating in Sunrise EquiTherapy, Inc.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Photo Release

I hereby consent to and authorize the use of reproduction by Sunrise EquiTherapy, Inc. of any and all photographs and any other audiovisual materials taken of me my son / my daughter / my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

\_\_\_\_ YES \_\_\_\_ NO

Signature (Client, Parent or Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

**Please return the completed rider registration packet to Sunrise EquiTherapy, Inc., Julie A. Wood, 2115 S. 214th, Eagle, NE 68347. Riders will not be allowed to participate in the program until said forms have been returned to Sunrise EquiTherapy. Please contact Julie Wood at 402-781-2781 for the location of the riding lessons.**

## **Authorization for Emergency Medical Treatment**

In the event emergency medical aid / treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Sunrise EquiTherapy, Inc, to:

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

Client Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

In the event I cannot be reached, please contact: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

Physicians Name: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Co: \_\_\_\_\_ Policy #: \_\_\_\_\_

### **Consent Plan**

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by a physician. This provision will only be invoked if the person below is unable to be reached.

Signature (Client, Parent or Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

### **Non-Consent Plan**

I do not give my consent for emergency medical treatment / aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment / aid is required, I wish the following procedures to take place:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Non-Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

**A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM.**

**Rider's Medical History and Physician's Statement** *to be completed annually*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Parents or Guardian: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

*\*\*For persons with Down Syndrome:*

Negative Cervical X-Ray for Atlantoaxial Instability X-Ray Date: \_\_\_\_\_

Negative for clinical symptoms of Atlantoaxial Instability

Tetanus Shot:  Yes  No Date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Seizure Type: \_\_\_\_\_ Controlled: \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

Medications: \_\_\_\_\_

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological			
Impairment			
Other			

**Current Tetanus Shot:**  Yes  No **Crutches:**  Yes  No **Braces/AFO's:**  Yes  No

**Wheelchair:**  Yes  No

Please indicate any special precautions: \_\_\_\_\_

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities / limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician Name: \_\_\_\_\_ Physician Signature: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Date: \_\_\_\_\_

**Physicians Prescription to be completed annually**

Name: \_\_\_\_\_

Prescription for Therapeutic Horseback Riding: \_\_\_\_\_

Prescription, where appropriate for evaluation and treatment by a Physical, Occupational, and/or Speech Therapist in conjunction with the Therapeutic Horseback Riding Operating Center: \_\_\_\_\_

Recommended Frequency: \_\_\_\_\_

Precautions: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Information for Physician**

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present and to what degree.

**ORTHOPEDIC**

- Spinal Fusion
- Spinal Instabilities/Abnormalities
- Atlantoaxial Instabilities
- Scoliosis
- Kyphosis
- Lordosis
- Hip Subluxation and Dislocation
- Osteoporosis
- Pathologic Fractures
- Coxas Arthrosis
- Heterotopic Ossification
- Osteogenesis Imperfecta
- Cranial Deficits
- Spinal Orthoses
- Internal Spinal Stabilization Devices

**NEUROLOGIC**

- Hydrocephalus/shunt
- Spina Bifida
- Tethered Cord
- Chiari II Malformation
- Hydromyelia
- Paralysis due to Spinal Cord injury
- Seizure Disorders

**MEDICAL/SURGICAL**

- Allergies
- Cancer
- Poor Endurance
- Recent Surgery
- Diabetes
- Peripheral Vascular Disease
- Varicose Veins
- Hemophilia
- Hypertension
- Serious Heart Condition
- Stroke (Cerebrovascular Accident)

**SECONDARY CONCERNS**

- Behavior problems
- Age under two years
- Age two - four years
- Acute exacerbation of chronic disorder
- Indwelling catheter



# SUNRISE EQUITHERAPY

## Participant's Application and Health History

To be completed by the participant or parent/legal guardian

### General Information

Participants Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: Male Female

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Alternate Phone: (\_\_\_\_) \_\_\_\_\_

Employer / School: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Parents or Guardian Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Contact Numbers: \_\_\_\_\_

How did you hear about Sunrise EquiTherapy? \_\_\_\_\_

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

What medications are you currently taking, including over-the-counter medications?

---

---

---

---

---

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

**Function.** (i.e., Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

---

---

---

---

---

**Social.** (i.e., Work/school, including grade completed, leisure interests, relationships-family structure, support system, companion animals, fears/concerns, etc.)

---

---

---

---

---

**Goals.** (i.e., why are you applying for participation? What would you like to accomplish?)

---

---

---

---

---



**Rider's Consent for Release of Information**

I hereby authorize (person or facility) \_\_\_\_\_

to release information for the records of (client's name) \_\_\_\_\_

The information is to be released to Sunrise EquiTherapy, Inc. for the purpose of developing a Therapeutic Riding Program for the above-named student. The information to be released is marked below:

- \_\_\_\_\_ 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: \_\_\_\_\_

Please send the indicated material to Sunrise EquiTherapy at 2115 South 214th Eagle, Ne 68347.