SPECIAL EQUESTRIAN RIDING THERAPY, INC.
SERT
PARTICIPANT'S APPLICATION AND HEALTH HISTORY

GENERAL INFORMATION **DATE:** _____

Participant: _____ **Email** _____

DOB: _____ **Age:** _____ **Height:** _____ **Weight:** _____ **Gender:** **M** **F**

Address: _____

_____

Home Phone: _____ **Occupation:** _____

Name of Father: _____ **Email** _____

Address (if different from above): _____

Home Phone: _____ **Employer:** _____

Occupation: _____ **Work Phone:** _____

Name of Mother: _____ **Email** _____

Address (if different from above): _____

Home Phone: _____ **Employer:** _____

Occupation: _____ **Work Phone:** _____

Legal Guardian (if applicable): _____

Address (if different from above): _____

Home Phone: _____ **Employer:** _____

Occupation: _____ **Work Phone:** _____

How did you hear about the program? _____

HEALTH HISTORY

Diagnosis _____ **Date of Onset:** _____

MEDICATIONS *(include prescriptions, over-the-counter: name, dose and frequency)*

_____

_____

_____

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

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

_____

_____

Participant's Application and Health History

HEALTH HISTORY

PSYCHO/SOCIAL FUNCTION (i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

GOALS (i.e. Why are you applying for participation? What would you like to accomplish?)

Please indicate current or past special needs in the following areas:

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

Completed by: _____ Relationship_____

SPECIAL EQUESTRIAN RIDING THERAPY, INC.

SERT

GENERAL AGREEMENT AND RELEASE FROM LIABILITY

The program offered by Special Equestrian Riding Therapy, Inc. ("SERT") is therapeutically oriented and controlled. All staff, volunteers and horses are specifically selected and trained. Safety equipment is used for all riders since riding is an inherently dangerous activity. No individual can be allowed to participate in any SERT program or activity until this form has been completed by the individual, if the individual is of legal age; or, if not, by his/her parent or guardian.

Name:_____ Date of Birth:_____

Address:_____ State:_____ ZIP:_____

Mother (if minor):_____ Phone (H):_____ (W)_____

Father (if minor):_____ Phone (H):_____ (W):_____

1. I,_____, acknowledge that I have voluntarily applied to participate in programs and activities offered by SERT at its facility located at 2182 Tierra Rejada Road, Moorpark, CA.

2. **I AM AWARE THAT RIDING AND WORKING WITH AND AROUND HORSES IS AN INHERENTLY DANGEROUS ACTIVITY. I AM VOLUNTARILY PARTICIPATING IN THESE ACTIVITIES WITH KNOWLEDGE OF THE DANGERS INVOLVED. I HEREBY AGREE TO ACCEPT ANY AND ALL RISKS OF INJURY AND/OR DEATH, AND VERIFY THIS STATEMENT BY PLACING MY INITIALS HERE: _____.**

3. As a consideration for being permitted by SERT or one of its affiliated organizations to participate in these activities and use their facilities, I hereby agree that I, my assignees, heirs, distributees, guardians, and legal representatives will not make a claim against, sue, or attach the property of SERT or any of its affiliated organizations, or the supplier of any of the equipment I will use in these activities, for injury or damage resulting from the negligence or other acts, whosoever caused, by any employee, agent or contractor of SERT or any of its affiliated organizations as a result of my participation in any SERT program or activity. I hereby release SERT, its agents, employees, officers, directors, representatives, assigns, members, owner of premises and trails, affiliated organizations, insurers and others acting on its behalf from all actions, claims, or demands that I, my assignees, heirs, distributees, guardians, and legal representatives now have or may hereafter have for injury or damage resulting from my participation in any SERT program or activity.

4. I HAVE CAREFULLY READ THIS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT BETWEEN MYSELF AND SERT AND/OR ITS AFFILIATED ORGANIZATIONS AND SIGN IT OF MY OWN FREE WILL.

Executed at_____, California on_____, 20_____

Signed:_____
Self, or if a minor, Parent(s) or Legal Guardian

Print Name: _____

HORSEPOWER THERAPEUTIC RIDING
RIDER RELEASE AND WAIVER OF LIABILITY ASSUMPTION OF RISK AND INDEMNITY AGREEMENT

Whereas,

_____,
(Rider's Full Name – Please Print)

will be participating as a rider in lessons and other equestrian activities organized by Horsepower Therapeutic Riding, a California corporation doing business as Horsepower Therapeutic Riding and/or by Marjolein Asher, (hereinafter referred to as "Horsepower TR");

Please initial one of the following:

_____ Now, therefore, I, the undersigned parent or legal guardian of the rider named above who is under 18 years of age, for myself and on behalf of the rider named above, his or her personal representatives , estate, heirs, assigns, and next of kin,

_____ Now, therefore, I, the rider named above, am 18 years of age or older, and I, my personal representatives, estate, heirs, assigns, and next of kin,

do hereby agree to give up any and all of my legal rights against Horsepower TR, its agents, employees, volunteers, officers, directors, representatives, assigns, members, owners of riding premises and trails used in its equestrian activities, affiliated organizations, insurers, people with whom it has contracts to provide facilities or services, including but not limited to Special Equestrian Riding Therapy (SERT) and Classic Equestrian Center, and all others acting on its behalf ("hereinafter collectively referred to as "RELEASED PARTIES"), as more specifically indicated below:

Acknowledgement of Danger and Assumption of Risk.
I acknowledge that riding horses, being near horses, and being at equestrian facilities and on trails, is inherently dangerous, and that no amount of care, caution, instruction, or supervision can eliminate such dangers.

I acknowledge such dangers include, but are not limited to the following:

1. A horse that may, among other things, buck, stumble, fall, rear, bite, kick, run, stomp, make unpredictable movements, spook, jump obstacles, step on a person's feet, and push or shove a person; saddles, bridles, or other equipment that may loosen, break, or otherwise malfunction; other riders who may not control their animals or ride within their ability, and cause a collision or other unpredictable consequence.
2. The negligent or intentional act or omission of RELEASED PARTIES or a third party.
3. Equestrian activities that may be conducted in areas that are subject to change in condition according to weather, temperature, and natural and man-made changes in landscape.
4. An apparent or hidden defect or dangerous condition of the equestrian facilities and trails.

Any of these and other known or unknown dangers may cause me to fall or be jolted or injured in another manner, resulting in the possibility of serious physical and emotional injury, and death. In addition, I acknowledge that such injury and death could result from self-inflicted injury and death.

Despite such dangers, I voluntarily assume the risk and danger of serious injury and death inherent in all equestrian activities organized by Horsepower TR.

Helmet Requirement.
I acknowledge that Horsepower TR has required me to wear protective headgear that meets or exceeds the quality standards of the SEI Certified/ASTM STANDARD F 1163 equestrian helmet at all times during mounting, riding, and dismounting horses, because the helmet may prevent or reduce the severity of some head injuries.

Release of Liability.
I agree to hold harmless, release and discharge RELEASED PARTIES from all claims, demands, causes of action, and legal liability that I may hereafter have for injuries, damages, and death related to Horsepower TR equestrian activities including but not limited to injury, damages, and death caused by the negligent or intentional acts or omissions of RELEASED PARTIES or third parties.

I shall not bring any claims, demands, legal actions, and causes of action against Released Parties for injury, damage, death, or other losses sustained by me in relation to Horsepower TR equestrian activities.

Indemnification.
I agree to indemnify and hold harmless RELEASED PARTIES as to all claims, actions, damages, costs and expenses, including attorney's fees sustained, as a result of my participation in Horsepower TR equestrian activities.

California Law.
This agreement is governed by the Laws of the State of California. In the event that any portion of this agreement is determined to be invalid, illegal, or unenforceable, the validity, legality and enforceability of the balance of the agreement shall not be affected or impaired in any way and shall continue in full legal force and effect.

I HAVE READ THIS RELEASE AND WAIVER OF LIABILITY ASSUMPTION OF RISK AND INDEMNITY AGREEMENT; I FULLY UNDERSTAND ITS TERMS AND UNDERSTAND THAT I AM GIVING UP SUBSTANTIAL RIGHTS BY AGREEING TO IT.

Dated: _____

Rider's full name (please print): _____

Rider's Signature (please sign if 18 or older): _____

Parent/Legal Guardian's full name (please print): _____

Parent/Legal Guardian's signature (please sign if rider under 18): _____

SPECIAL EQUESTRIAN RIDING THERAPY, INC.

SERT

Emergency Medical Treatment Release

☐ Participant ☐ Staff ☐ Volunteer

Consent Plan

I (we) the undersigned, as self, parent/parents and /or legal guardian of _____ Self/minor, do hereby authorize and consent to any X-ray examination, anesthetic, or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act or a Dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the state of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact parent(s) and/or legal guardians prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the parent(s) and/or legal guardians cannot be reached.

List of any restrictions_____

Date_____ Signature_____ Print Name_____
Self, or if a minor, Parent(s) or Legal Guardian

_____
Address City State Zip

In case of emergency, contact:

_____ _____ _____
Name Relationship Home Phone Work or Cell Phone

_____ _____ _____
Name Relationship Home Phone Work or Cell Phone

Medical Insurance Company _____ Policy#_____

Subscriber's Name _____ Group#_____

This consent shall remain effective until _____

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 performing services or while being on the property of the agency.

Parent or legal guardian will remain on site at all times during equine assisted activities

In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

Date_____ Signature_____ Print Name_____

SPECIAL EQUESTRIAN RIDING THERAPY, INC.

Dear Health Care Provider:

Your patient, _____
(Participant's Name)

is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability-include neurological symptoms
Coxarthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spins Bifida/Chiari II malformation/
Tethered Cord/Hydromyelia

Other
Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i. e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA ,MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at 805/523-1244 or 818/776-6476.

Sincerely,

Connie Gilly
Program Director

Self, or if a minor, Parent(s) or Legal Guardian (*Signed in presence of center staff)*

POST OFFICE BOX 42 *MOORPARK, CA 93020-0042* (805) 523-1244 * WWW.SERT.ORG

SPECIAL EQUESTRIAN RIDING THERAPY

SPECIAL EQUESTRIAN RIDING THERAPY, INC.

SERT

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

TO BE COMPLETED BY A PHYSICIAN

Participant: _____ **DOB:** _____ **Height:** _____ **Weight:** _____

Address: _____

Diagnosis: _____ **Date of Onset:** _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ **Controlled: Y N Date of Last Seizure:** _____

Shunt Present: Y N Date of Last Revision: _____

Special Precautions/Needs: _____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: _____

***For those with Down Syndrome*: AtlantoDens Interval X-rays, date:** _____ **Result: + --**

Neurologic Symptoms of AtlantoAxial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

SPECIAL EQUESTRIAN RIDING THERAPY, INC.
SERT
PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant's Name: _____

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the NARHA 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Name/Title: _____MD DO NP PA Other _____

Signature: _____ Date: _____

Stamp:

Address: _____

Phone: ( ) _____ License/UPIN Number:_____