THERAPEION THERAPEUTIC RIDING PROGRAM AT COURAGE ROCK STABLE
PARTICIPANT REGISTRATION & HEALTH HISTORY
YEAR 2026

The minimum age for participation is four years old

Participants Name:_____Nickname: _____
Address: _____
City:_____ State: _____ Zip: _____
Date of Birth:_____ Age: _____

If Applicant is under 18, the information below refers to the Parent or Guardian.

Parent/Guardian: _____ I am ☐ Parent ☐ Legal Guardian
Phone Number:_____Email Address: _____
Address: (if different than above) _____
Employer:_____Work phone: _____
For class information or changes, how would you like us to notify you? ☐Text ☐Call ☐Email

Class Information Contact Information

Contact 1 Name: _____Phone or Email: _____
Contact 2 Name: _____Phone or Email: _____

LIABILITY RELEASE

Indiana State Equine Laws states that: *Under Indiana law, an equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.*

_____ (Participant's name) would like to participate in the Therapeion Therapeutic Riding Program at Courage Rock Stable Inc. I acknowledge the risks and potential for risks of horseback riding and equine activities. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than 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 to damages against Courage Rock Stable Inc, its Board of Directors, Instructors, Therapists, Aides, Volunteers, Employees, Stable Owners, and/or Stable Employees, as well as for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in the Therapeion Therapeutic Riding Program.

Date: _____ Signature: _____
Parent, Guardian, or Applicant (if applicant is over 18 years of age)
Print Name: _____

PHOTO RELEASE (CONSENT)

I hereby consent to and authorize the use and reproduction by Courage Rock Stable 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, media, website or for any other use for the benefit of the program.

Date: 01/28/2026Signature: _____
Parent, Guardian, or Applicant (if applicant is over 18 years of age)

PHOTO (NON-CONSENT) SIGNATURE

Date: 01/28/2026 Signature: _____
Parent, Guardian, or Applicant (if applicant is over 18 years of age)

THIS FORM IS TO BE UPDATED ANNUALLY

THERAPEION THERAPEUTIC RIDING PROGRAM
Authorization for Emergency Medical Treatment

Emergency Information

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 Courage Rock Stable, to secure medical treatment and/or emergency transportation if needed and to release participant's records upon request to the authorized individual or agency involved in the medical emergency treatment.

Participant Name: _____

Emergency Contact Information:

Name: _____ Relationship: Mother

Cell phone: (999)999-9999Home phone: (999)999-9999Work phone:(999)999-9999

Participant Doctor Information:

Name: _____ Phone: (999)999-9999

City: _____ State: _____ ZIP: _____

Hospital: _____ City: _____

CONSENT

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed lifesaving by the physician. This provision will ONLY be invoked if the person listed as the emergency contact is unable to be reached.

Consent Signature:_____ Date: 01/28/2026

Parent, Guardian, or Client (if client is over 18 years of age)

Print name: _____

NON-CONSENT

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 Courage Rock Stable Inc.

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

Your text here

Non-Consent Signature: _____ Date: 01/28/2026

Parent, Guardian, or Client (if client is over 18 years of age)

Print name: _____

Address: _____

City: _____ State: _____ ZIP: _____

DISMISSAL POLICY: you will receive an information letter that contains our dismissal policy.

Dismissal of a participant will be considered if the participant exceeds our weight limit or if they are determined by a PATH Intl Instructor to potentially be a danger to themselves, our staff, or our equines or they violate the barn rules.

Dismissal of a family member/caregiver/guardian will be considered if they violate the barn rules or a PATH Intl Instructor determines they could potentially be a danger to themselves, our staff, or our equines.

All dismissals will be in written form.

COURAGE ROCK STABLE INC.
HEALTH HISTORY/PHYSICIAN RELEASE
ALL PAGES OF THIS FORM MUST BE UPDATED ANNUALLY by THE PHYSICIAN'S OFFICE

Form Completion Date: _____ Participants Date of Birth: _____
Participant Name: _____
Street Address: _____
City _____ State: _____Zip: _____
Name of Parent or Guardian: _____

Diagnosis: _____
_____
Medication names and doses: _____
_____
Allergies: _____

Tetanus Shot Current? Yes No

Height _____ Weight _____ (*clients over 180 pounds may not be able to ride due to safety factors)*

**********FOR PERSONS WITH DOWNS SYNDROME*********
Full flexion and extension X-rays for Atlantoaxial Instability (AAI) is required within 5 years prior to entering the Therapeion Therapeutic Riding program. Annual physical examination should reveal no symptoms of AAI. Follow-up X-rays should be every 10 years after.

NO INDIVIDUAL MAY RIDE WITH POSITIVE SYMPTOMS OF AAI.
Cervical X-ray for AAI Negative _____ Date _____ Doctor's Initials _____

MEDICAL HISTORY
Please circle **Yes** *or* **No** *for each of the following conditions. The presence of a condition will need to be further evaluated before it is determined if it is appropriate for the client to receive riding instruction.*
This is for the client's safety.

Spinal Fusion: Yes No Location and type_____

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: _____

THERAPEION THERAPEUTIC RIDING PROGRAM
HEALTH HISTORY/PHYSICIAN RELEASE
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Participants Name: _____

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

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

Helmet Use:

During riding activities, participants are required to wear helmets that are American Society for Testing and Materials – Safety Equipment Institute (ASTM-SEI) certified for equestrian use. If the use of an ASTM-SEI helmet is not appropriated, then a Consumer Product Safety Commission (CPSC) approved helmet for bicycle riding, or an ASTM-SEI approved helmet for other sports may be considered if it provides adequate coverage over the back of the head.

******Physician, please submit a written evaluation and justification that specifically addresses the risk of equine activities to determine whether the use of an alternative helmet is necessary and a recommended type to use.***

My signature indicates I have found no medical reason that this individual cannot participate in Therapeion program.

Name/Title: _____MD DO NP PA Other _____

Signature: _____Date: _____

Address: _____

Phone (_____) _____ License/UPIN Number: _____