



**THERAPEION THERAPEUTIC RIDING PROGRAM AT COURAGE ROCK STABLE  
PARTICIPANT REGISTRATION & HEALTH HISTORY  
2024**

*\*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: \_\_\_\_\_ Signature: \_\_\_\_\_

*Parent, Guardian, or Applicant (if applicant is over 18 years of age)*

**PHOTO (NON-CONSENT) SIGNATURE**

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

Cell phone: (\_\_\_\_) \_\_\_\_\_ Home phone: (\_\_\_\_) \_\_\_\_\_ Work phone:(\_\_\_\_) \_\_\_\_\_

**Participant Doctor Information:**

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

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: \_\_\_\_\_

*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:

\_\_\_\_\_

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

*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.

**THIS FORM IS TO BE UPDATED ANNUALLY**

**THERAPEION THERAPEUTIC RIDING PROGRAM  
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**

**Page two**

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: \_\_\_\_\_