**SANTA YNEZ VALLEY THERAPEUTIC RIDING PROGRAM**
Site: 195 Refugio Rd., Santa Ynez, CA • Mailing: PO Box 256, Solvang, CA 93464
805-686-6739 • www.syvtherapeuticriding.org



# Rider Application

## AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

**Name**_____ **DOB:**_____ **Phone:**_____

**Address:**_____

**Physician's Name:**_____ **Preferred Medical Facility:**_____

**Health Insurance Company:**_____ **Policy#:**_____

**Allergies to medications:**_____

**Current medications:**_____

**In the event of an emergency, contact:**

**Name:**_____ **Relation:** _____ **Phone:**_____

**Name:**_____ **Relation:** _____ **Phone:**_____

**Name:**_____ **Relation:** _____ **Phone:**_____

**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 Santa Ynez Valley Therapeutic Riding Program 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.**

**Consent Plan:**
This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date:_____ Consent Signature:_____
Client, Parent or Legal Guardian
*Signed in presence of center staff*

**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.

- ☐ Parent or legal guardian will remain on site at all times during the equine assisted activities
- ☐ In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

_____

Date:_____ Consent Signature:_____
Client, Parent or Legal Guardian
*Signed in presence of center staff*

## PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

**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 | | | |

To my knowledge, there is no reason why this person cannot participate in supervised equestrian 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 DP NP PA Other_____

Signature:_____ Date:_____

Address:_____

Phone: ( )_____ License/UPIN Number:_____

**MEDICATIONS** ***(include prescription, over-the-counter; name, dose and frequency)***_____

_____

_____

_____

_____

_____

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

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

_____

_____

_____

_____

_____

**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?)**_____

_____

_____

_____

_____

_____

**Signature:**_____ **Date:**_____

**PHOTO RELEASE**

**I** ☐ DO

☐ DO NOT

consent to and authorize the use and reproduction by SYVTRP of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

**Signature:**_____ **Date:**_____

Client, Parent or Legal Guardian
*Signed in the presence of center staff*

# SANTA YNEZ VALLEY THERAPEUTIC RIDING PROGRAM AND SANTA YNEZ VALLEY EQUESTRIAN ASSOCIATION, INC. RELEASE/WAIVER AND HOLD HARMLESS AGREEMENT

I am aware and fully understand that horses can be unpredictable and dangerous animals. I realize that participants and even spectators attending equestrian events place themselves in a potentially hazardous environment that poses a substantial risk of injury to person and property and that occasionally serious injury or even death to riders, spectators and horses occurs. Nevertheless, by my signing this agreement, I hereby, knowingly and voluntarily, with full appreciation for the danger, assume all risks of injury to my person and/or property, no matter how catastrophic and no matter the cause, which may occur as a result of my participation in or attendance at the event.

_____ (initial)

In consideration for allowing me to participate and/or be a spectator at these events, on behalf of myself, my heirs and my estate, I hereby release and hold harmless the Santa Ynez Valley Therapeutic Riding Program and the Santa Ynez Valley Equestrian Association, the property owners and the operators of the events, their employees, agents and assigns, from any and all duty, liability or responsibility to me, my estate, heirs and assigns, that may arise from an accident, damage, injury or illness to me or my property as a result of my participation in or attendance at the equestrian events scheduled for the calendar year, <u>including, but not limited to, any and all damage, injury or illness to me, my person or property, that may arise from the negligent acts or omissions of the Santa Ynez Valley Therapeutic riding Program and the Santa Ynez Valley Equestrian Association or the operators of its events or their respective employees, agents and assigns, even if the negligent acts or omissions occur after I am injured.</u>

_____ (initial)

By signing this release, I hereby grant the operators of this event, their employees, agents and assigns my permission to initiate emergency first aid treatment for myself and/or my children in the event such treatment is reasonably required, which determination may be made in their sole discretion.

_____ (initial)

I also agree to defend, indemnify and hold harmless the Santa Ynez Valley therapeutic riding Program and the Santa Ynez Valley Equestrian Association, the property owners and the operators of this event, their employees, agents and assigns, against all claims, demands and causes of action (which includes court costs and attorney's fees), prosecuted for my benefit. I agree that this release extends to all claims of every kind an nature whatsoever whether known or unknown and expressly waive any benefits of California Civil Code section 1542 which states:

> A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM MUST HAVE MATERIALLY AFFECTED HIS SETTLEMENT WITH DEBTOR.

_____ (initial)

I have carefully read each point listed above and agree to each statement.

**PRINTED NAME OF PARTICIPANT:**_____

**ADDRESS:**_____

**SIGNATURE OF PARTICIPANT:**_____

*(if participant is an adult, or parent or guardian if participant is a minor)*

**DATE:**_____

*(must be dated)*