



RIDING ON ANGELS' WINGS RIDERS REGISTRATION AND RELEASE FORM

RIDER'S NAME : _____ DOB: _____ DATE: _____

STREET: _____ CITY: _____ ZIP: _____

HOME PHONE: (____) _____ WORK PHONE: (____) _____ EMERGENCY (____) _____

PARENTS OR GUARDIAN _____

ADDRESS/PHONE IF DIFFERENT THAN ABOVE: _____ PARENTS/GUARDIAN E-MAIL _____

SEX _____ WEIGHT _____ HEIGHT _____ SCHOOL/GROUP HOME _____

PRIMARY DISABILITY: _____ OTHER DISABILITIES _____

HAS STUDENT EVER RIDDEN A HORSE: _____ YES _____ NO

MOBILITY: INDEPENDENT AMBULATION	_____ YES	_____ NO
ASSISTED AMBULATION	_____ YES	_____ NO
WHEELCHAIR	_____ YES	_____ NO
BRACES/ASSISTIVE DEVICES	_____	_____

For Office Use Only

Helmet Size _____

SPECIAL PRECAUTIONS/NEEDS: _____

*****FOR PERSONS WITH DOWN SYNDROME:**

_____ NEGATIVE CERVICAL X-RAY FOR ATLANTOAXIAL INSTABILITY. X-RAY DATE _____
 _____ NEGATIVE FOR CLINICAL SYMPTOMS OF ATLANTOAXIAL INSTABILITY.

TETNUS SHOT: Yes ___ No ___ Date ___ 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 _____			

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 the person's abilities/limitations by a licensed/credentialed health professionals in the implementing of an effective equestrian program.

Physician Name (Please print) _____ Date _____ Phone _____

Physicians Signature _____

Address _____ City _____ State _____ Zip _____

RIDER'S AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

In the even of an 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 Riding On Angels' Wings 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's Name: _____ Phone: _____

Address: _____

In the event I cannot be reached, contact: _____ Phone: _____

Or contact: _____ Phone: _____

Physician's 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 the physician. This provision will only be invoked if the person below is unable to be reached.

Date: _____ Print Name: _____ Phone: _____

Address: _____

Consent Signature _____

Client, Parent or Guardian

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 Riding on Angels' Wings. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date: _____ Print Name: _____ Phone: _____

Address: _____

Non-Consent Signature: _____

"Riding on Angels' Wings"
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