The Reece Center

Rider's Consent for Release of Information

I hereby authorize: _____
(Person or Facility)

to release information from the records of: _____
(Student's Name)

The information is to be released to: _____
(Operating Center's Name)

for the purpose of developing a Riding Program for the above-named student. The information to be released is marked below.

____ Medical History
____ Physical Therapy evaluation, assessment, and program plan
____ Occupational Therapy evaluation, assessment, and program plan
____ Speech Therapy evaluation, assessment, and program plan
____ Classroom Individual Education Plan (I.E.P.)
____ Other: _____

Date: _____ **Signature:** _____
(Client, Parent or Guardian)

Please send the indicated material to _____
(Operating Center's Name)

The Reece Center

Riding Instruction Consent Form

Student Name: _____

Address: _____ **City/State/Zip Code:** _____

Phone: _____ **Date of Birth:** _____

Disability: _____ **Date of Onset:** _____

No student can be accepted for riding instructions until the Parent(s) and or Guardian(s) have completed this form. If the student is of legal age (19), he or she may complete the form if he or she is legally competent to do so. Riding instructions will be under strict supervision and although every effort will be made to avoid any accident, NO LIABILITY can be accepted by any of the organizations concerned including The Reece Center.

Physician's Name: _____

Office Address: _____

City/State/Zip Code: _____ **Phone:** _____

I would like _____
to have riding instruction and I have discussed this with the student's doctor. I understand NO LIABILITY can be accepted by any organizations concerned with this instruction, including The Reece Center in the event of any accident occurring.

Signature of Parent/Guardian: _____

Signature of Student over 19: _____

We would appreciate any further information about the student that you as a Parent or Guardian think would be helpful. Especially pertinent information would be fears of any kind, including animals, heights, etc.

The Reece Center

Rider Registration Form

Student: _____ **Phone:** _____

Email: _____

Address: _____ **City/State/Zip Code:** _____

Date of Birth and Present Age: _____/_____ **Grade:** _____

Height: _____ **Weight:** _____

Please name two persons other than parents as those to contact in case of emergency:

Name: _____ **Phone:** _____

Name: _____ **Phone:** _____

Brief explanation of disability: _____

_____

Physicians' Name: _____ **Office Phone:** _____

Address: _____ **City/State/Zip Code:** _____

No student can be accepted for riding instruction until this form has been completed. If the student is of legal age (19), he or she may complete the form without the Parent(s) or the Guardian(s) signature. Riding instruction will be under strict supervision and although every effort will be made to avoid any accident, NO LIABILITY can be accepted by any of the organizations or individuals connected with The Reece Center.

Signature of Parent/Guardian: _____ **Date:** _____

Phone: _____

Signature of Student over age 19: _____ **Date:** _____

Do Not Write Below This Line

****

Approved For Instruction By: _____ **Date:** _____

Assessment Approved By: _____ **Date:** _____

The Reece Center
Rider Liability Release Agreement

Student: _____ Phone: _____

Address: _____

Parent/Guardian's Full Name _____ Phone: _____

I/We, the student or parents/guardian of the above-named student, who is applying for participation in The Reece Center program, hereby give consent and approval to participate in any and all activities of the program. I/we assume all risk and hazard incidental to the conduct of the activities as well as transportation to and from the activities.

I/We do further release, absolve, indemnify, and hold harmless The Reece Center, its officers, employees, representatives, successors and assigns, for all manner of claims, demands and damages of every kind and nature whatsoever on account of any personal injuries, physical or mental condition, known or unknown, as a result of, or in any way growing out of participation in The Reece Center program.

The undersigned do (does) hereby authorize and give permission to The Reece Center and its staff, individually or together, to act on behalf of the undersigned in requesting and authorizing the provision of emergency medical services as deemed necessary in their discretion to the student.

The undersigned guarantees payment of all customary fees and charges in connection with the rendering of such emergency medical services.

This release/authorization shall be effective during the period beginning on (date) _____ and continuing through the period that the student is involved with The Reece Center program and is not revocable during such period.

Signature of Student over age 19:_____

Date: _____

*****If the student is not legally able to sign for himself/herself, both parents/legal guardians must sign this form. If only one-parent/legal guardian signs, please give reason in the space provided below.

Mother: _____ Date: _____
Father: _____ Date: _____
Guardian:_____ Date: _____
Guardian:_____ Date: _____

Reason for only one signing: _____
_____
_____
_____

The Reece Center
Authorization for Emergency Medical Treatment

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 The Reece Center to:

1. Secure and retain medical treatment and transportation if needed.
2. Release student records upon request to the authorized individual or agency involved in the medical emergency treatment.

Student's Name: _____ Phone: _____

Address: _____

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

Physician's Name: _____ Phone: _____
Preferred Medical Facility: _____ Phone: _____
Health Insurance Company: _____ Policy #: _____

CONSENT PLAN

This authorization included x-ray, surgery, hospitalization, medication, and any treatment procedures deemed "lifesaving" by the physician. This provision will only be invoked if the person listed below is unable to be reached.

Consent Signature: _____ Date: _____
Relationship to student (self, parent, guardian): _____
Print Name: _____ Phone: _____
Address: _____

NON-CONSENT PLAN

I do not give my consent for emergency treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____
_____
_____
_____

Non-Consent Signature: _____ Date: _____
Relationship to student (self, parent, guardian): _____
Print Name: _____ Phone: _____
Address: _____

The Reece Center
Rider Photo Release Form

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grant(s) to The Reece Center permission to take or have taken, still and moving photographs and films, including television pictures of _____
and consent(s) and authorizes The Reece Center, its advertising agencies, news media, and any other persons interested in The Reece Center and its work to use and reproduce photographs, films, and pictures to circulate and publicize the same by all means including without limited the generality of the foregoing newspapers, television media, brochures, pamphlets, instructional materials, books, web sites, social media and clinical material.

With regard to the foregoing, no inducements or promises have been made to us/me to secure our/my signature(s) to this release other than the intention of The Reece Center to use such photographs, films, or pictures for the primary purpose of promoting and aiding The Reece Center and its work.

Dated this _____ day of _____, 20 _____

Consent Signature: _____ Date: _____
Relationship to student (self, parent, guardian): _____
Print Name: _____ Phone: _____
Address: _____

Consent Signature: _____ Date: _____
Relationship to student (self, parent, guardian): _____
Print Name: _____ Phone: _____
Address: _____

****

Georgia Law with regard to Equine Activities

WARNING! Under Georgia Law, an equine activity sponsor or 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, pursuant to Chapter 12 of Title 4 of the official code of Georgia annotated.

I, the undersigned, have read and understand the above statement.

Rider signature: _____

Parent/guardian signature (if applicable): _____

Witness signature: _____ Date: _____

The Reece Center
Medical History/Physician Release

Rider Name: _____DATE:_____

D.O.B__/__/__AGE:___Sex:_____Height:_____Weight:_____Pulse:_____B.P.:_____

Diagnosis:_____

Cause:_____

Medications (Type, Purpose, Dose):_____

_____

If Downs Syndrome, Atlanto-Axial Subluxation? Yes____ No___

Cervical X-Ray for Atlanto-Axial Subluxation: Positive____ Negative___ X-Ray Date:___/___/___

Tetnus Shot: Yes___ No___ Date:___/___/___

Please indicate if the client has or has a history of the following secondary problems by checking "Yes" or "No". If YES please include COMPLETE information pertaining to the problem.

PROBLEM	YES	NO	IF "YES" OR "HISTORY OF" PLEASE DESCRIBE
Auditory Impairment			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Speech Impairment			
Visual Impairment			Glasses:
Allergies			
Cardiac			

PROBLEM	YES	NO	IF "YES" OR "HISTORY OF" PLEASE DESCRIBE
Circulatory			
PVD			
postural hypotension			
hemophilia			
Pulmonary			
Asthma/COPD			
Muscular			
contractures			
Neurological			
seizures/controlled			**Type:**
last seizure: / /			
hydrocephalus			
shunt			
sensory loss			
pain			

Information for Physician

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

	Yes	No
Spinal Fusion		
Spinal Instabilities		
Spinal Abnormalities		
Scoliosis		
Kyphosis		
Lordosis		
Hip Subluxation & Dislocation		
Osteoporosis		
Pathologic Fractures		
Coxas Arthrosis		
Heterotopic Ossification		
Osteogenesis Imperfecta		
Cranial Deficits		
Spinal Orthoses		
Internal Spinal Stabilization Devices		

Medical/Surgical

	Yes	No
Allergies		
Cancer		
Poor Endurance		
Recent Surgery		
Diabetes		
Peripheral Vascular Disease		
Varicose Veins		
Hemophilia		
Hypertension		
Serious Heart Condition		
Stroke (Cerebrovascular Accident)		

Neurologic

Hydrocephalus/shunt		
Spina Bifida		
Tethered Cord		
Chiari II Malformation		
Hydromyelia		
Paralysis (spinal cord injury)		
Seizure Disorders		

Secondary Concerns

Behavior problems		
Acute exacerbation of chronic disorder		
Indwelling catheter		

Please indicate any medical problems not indicated above or if "YES" to any of the above, please describe:_____

_____

Please indicate special precautions:_____

_____

_____

Mobility Status

	Yes	No
Independent ambulation		
crutches		
braces		
wheelchair		

Please indicate special precautions:_____

Prosthetics

Type:_____ **Purpose:**_____

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 this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician Name (Please Print)_____

Physician Signature:_____

Address:_____**City:**_____**State:**_____**Zip:**_____

Phone:_____ **Date:**_____