



Hugs for Horses
THERAPEUTIC RIDING CENTER - GEORGETOWN, SC

Hugs for Horses Therapeutic Riding Program

Rona Jacobs, Director
215 Equestrian Drive
Georgetown, SC 29440

Phone: 843.833.3929
Email: info@hugsforhorses.org
Web: <https://www.hugsforhorses.org>

Rider Information and Waivers Form for Learning with Horses

Date: _____

Please complete entire form (2 pages.) If a question is not applicable to your rider, please write in "NA." Incomplete applications cannot be considered.

1. Rider Name: _____	2. Birthdate: _____	3. Age: _____	4. Height: _____ ft. in.	5. Weight: _____ lbs.
6. Rider T-Shirt Size. Please circle one: ADULT- Sm, M, L, XL, 2XL, 3XL OR YOUTH- XS, S, M, L, XL				
7. My rider attends the following school: _____ Grade just completed: _____				
8. Race/Ethnicity: _____ Gender: Male: _____ Female: _____ Unspecified: _____ (Black or African American, White, Hispanic, Native American, other (please specify))				

Rider Information

9. Rider's background information you'd like to share: _____

10. Does rider struggle to succeed in school? YES NO In what ways? _____

11. Please place an "X" by and describe any rider health issues that could impact the rider's balance, alertness, or performance while on a horse.

Seizures _____ Allergies _____

Diabetes _____ Other _____

Medications taken regularly that can affect balance, alertness, or coordination _____

12. Concerns / Additional Rider Information: _____

13. Physician name: _____ Physician Phone number: _____
Physician address: _____

Contact Information

14. Parents'/Guardians' Names: _____

15. Mailing Address: _____

In which county do you live? _____

16. Email Addresses: Place an "X" by preferred email address for contact by Hugs' personnel

17. Phone Numbers: Place an "X" by preferred phone numbers for contact by Hugs' personnel
 Home: _____ Work: _____
 Mobile 1: _____ Mobile 2: _____

Do you wish to be contacted via text message on your mobile phone? YES NO



Rider Name: _____ **Date:** _____

Photo / Video Release

- I DO
 DO NOT

consent to and authorize the use and reproduction of any photographs or videos taken of my rider for promotional or informational purposes such as brochures, web sites, and presentations, solicitation of funding, or any other use for the benefit of the Hugs for Horses Therapeutic Riding Program.

Name Release

- I DO
 DO NOT

consent to and authorize the disclosure of my rider's name in "good news" press releases and success stories submitted to promote awareness of Hugs for Horses Therapeutic Riding Program and the benefits of therapeutic riding.

Medical Disclaimer

To my knowledge my rider has no health condition that would keep him/her from participating in therapeutic horseback riding safely.

➔ **Signature:** _____ **Date:** _____
Parent, Legal Guardian, or Client who is able to give legally adequate consent

WARNING

Under South Carolina Law, an Equine Activity Sponsor or Equine Professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of equine activity pursuant to Article 7, Chapter 9 of Title 47, and Code of Laws of South Carolina, 1976.

Hugs for Horses Therapeutic Riding Program, the Georgetown County Board of Disabilities and Special Needs, the Georgetown Equestrian Center, the property owners, or any employee/volunteer/board member of Hugs for Horses Therapeutic Riding Program or the Georgetown Equestrian Center or the Georgetown County Board of Disabilities and Special needs will not be held responsible for any injuries that may occur.

➔ **Signature:** _____ **Date:** _____
Parent, Legal Guardian, or Client who is able to give legally adequate consent

It is the responsibility of the Parent, Legal Guardian, or Client who is able to give legally adequate consent to notify Rona Jacobs, Hugs Director, of any changes in rider's vital information including medical status, physician approval, contact information, and waivers and releases choices. Parent, Legal Guardian, or Client who is able to give legally adequate consent will submit a new Rider Information and Waivers Form and physician referral to document the changes. In addition, Hugs may require updated forms and physician referrals at any time for rider to continue in the program.

For use by Hugs' personnel only:

Application received by: _____ Date: _____ Waiting list, on date: _____
 Medical release received (date) _____ written by: _____ on date: _____
Client placed in Group Class: day and time: _____ start date: _____
 Private or semiprivate: day and time: _____ start date: _____