



Hugs for Horses  
THERAPEUTIC RIDING CENTER - GEORGETOWN, SC

## Hugs for Horses Therapeutic Riding Program

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### Rider Information and Waivers Form

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: _____ Teacher: _____				
8. My rider participates in these recreational and/or therapeutic activities: _____				

### Rider Medical Information

9. Description of disability (ies) :

10. Has rider been diagnosed with Autism Spectrum Disorder?  YES  NO

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. Referring physician or therapist and specialty: \_\_\_\_\_

Referring physician/therapist location: \_\_\_\_\_

### 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



**Hugs for Horses Therapeutic Riding Program  
Rider Information and Waivers Form**

**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 Hugs 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 Hugs 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.

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

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: \_\_\_\_\_

Waiting list, on date: \_\_\_\_\_