HEROES ON HORSEBACK PARTICIPANT REGISTRATION FORM

Phone: 843-757-5607 ♦ Fax: (866) 292-0834

Calendar Year 2023

Please note that all paperwork must be received 1 week prior to the start of each session.

Thank you for your interest in Heroes on Horseback (HOH). The first step toward participating in a HOH program is to complete and return the necessary forms. These forms are valid for one year. If you have current forms on file, then you need only to complete the Continuing Registration Form.

Before a participant can be considered for inclusion in the Heroes on Horseback programs the attached forms must be completed and returned to Heroes on Horseback.

- New and present participants must meet the HOH age and weight policy as stated on attached sheet
- Physician's cover letter and medical history & physician's statement must be completely filled out and signed by the participant's physician
- Participant's Authorization for Emergency Medical Treatment to be completed
- Participant's Application and Health History to be completed

Once all forms are received at Heroes on Horseback and are verified for completeness, an evaluation will be arranged. The deposit for the session is $25. During the evaluation, we will ensure that our program is appropriate for the potential participant and that there are no contraindications to participation in horseback riding activities. A brief mounted evaluation will take place if appropriate. After being accepted into the program, **please return the session forms and fees immediately.** Receipt of your payment will reserve your space in the riding session. Spaces are reserved on a first come first serve basis.

HOH strives to provide the safest possible conditions for participants, volunteers, employees and horses. The acceptance and continued participation of a participant in our program depends on the availability of instructors, volunteers and suitable horses, and is based on our determination that we can safely accommodate the participant. HOH adheres to precautions and contraindications for participants established by PATH, Intl. HOH retains the right to refuse any participant that we cannot safely accommodate. Participants must inform HOH of changes in their health status and an annual update of the Medical History Form and Physician's Form is required.

Individual tuition cost per session is $350 – Special Olympics exempt, invoiced after first class and due within 30 days. Please contact us regarding special Tuition Assistance for qualified riders. Persons seeking Tuition Assistance should complete a Tuition Assistance Form.

We thank you for your interest and look forward to serving you soon. Please feel free to contact the office if you have any questions at (843) 757-5607.

Sincerely,

Janet Dishart
Program Director

Phone: 843-757-5607 ♦ Fax: (866) 292-0834

POLICIES

Unfortunately, riding is not an appropriate activity for everybody, and we occasionally have to decline services to those for whom riding is contraindicated. As a PATH (Professional Association of Therapeutic Horsemanship, Intl.) Premier Accredited program, we must follow PATH guidelines. To comply with PATH national standards, we have established the following:

Session Fees Policy

For riders to participate in the program, there is a $25 dollar deposit for each rider, due one week prior to the start of a session. The remainder of the balance is due within 30 days of the invoice date. If you are setting up a payment plan, please make arrangements with the office prior to the beginning of the upcoming session.

Age Policy

Minimum Age: 3 years old for therapeutic riding lessons
Maximum Age: There is not a maximum age. The only requirement is that the person is able to physically and safely perform what is required in a therapeutic riding lesson.

Weight Policy

According to PATH guidelines, riding is contraindicated:

1. If the staff is unable to safely manage the participant in any situation, including an emergency dismount.
2. If safety or comfort of the horse is compromised during mounted activities.
3. In determining if rider is weight appropriate, certain factors such as cognitive skills and the balance of the rider are considered at the time of assessment. Riders will be evaluated by staff to determine if riding is a safe and appropriate activity.

Tuition Refund Policy

- If a rider cancels prior to session classes commencing, full tuition minus a $25 deposit is refunded.
- If a rider cancels on the first day of class, one-half of the tuition will be refunded.
- No refunds are available after the first day of class.

Absence / Make-Up Class Policy

- Classes are held rain or shine.
- If a rider is absent, there is no make-up class. Make-up classes are scheduled only when HOH cancels a class.
- A number of volunteers commit their time to ensure a safe ride. Therefore, we request 24 hr. notice when a rider knows they will be absent.

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Participant Registration and Photo Release Form

Participant Name:	Date of Birth:	Sex: M F
Address:	City:	State / Zip:
Home Phone:	Cell Phone:	E-mail:
Parent (custodial) or Guardian:	Address if different:	Phone if different:
School or Programs presently attending: Please describe previous experience with horses / riding (no experience is required):		
Parent/Guardian's Employer and Contact Information: Parent/Guardian Signature _____ Printed Name_____ Date: _____		

Photo Release Consent

- ❑ I consent Date: _____ Signature _____
  Client/Parent/Guardian

- ❑ I do not consent Date: _____ Signature _____
  Client/Parent/Guardian

to and authorize the use and reproduction by Heroes on Horseback 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 this program.

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Authorization of Emergency Medical Treatment Form

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 Heroes on Horseback to secure and retain medical treatment and transportation if needed, and release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Participant Name:	Phone:	Phone:
Address:	City:	State / Zip:
If I cannot be reached Contact:	Phone:	Phone:
Alternate Emergency Contact:	Phone:	Phone:
Physician's Name:	Phone:	
Preferred Medical Facility:		
Health Insurance Company:	Policy #:	

Consent Plan
The authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Consent Signature: (Client, Parent or Guardian):	Date:
Please Print Name:	Phone #:

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. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Consent Signature: (Client, Parent or Guardian):	Date:
Please Print Name:	Phone #:

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Client Medical History & Physician's Statement

This form to be completed by a medical professional if the current form we have on file is older than 3 years from the start date of the session

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Participant Name:	**Date of Birth:**	**Sex:**	**Race:**	**Height**	**Weight:**
Name / Address of Guardian:			**Tetanus Shot: YES NO Date:**		
Diagnosis:			**Date of Onset:**		
Medications:					

Please indicate if patient has a problem and/or surgical history in any of the following areas:

AREA	YES	NO	COMMENTS	AREA	YES	NO	COMMENTS
Auditory				Muscular			
Visual				Independent Ambulation			
Speech				Crutches			
Allergies				Braces			
Cardiac				Wheelchair			
Circulatory				Neurological			
Learning Disability				Orthopedic			
Mental Impairment				Pulmonary			
Psychological Impairment				Other			
Seizures			Type:	Controlled:			Date of Last Seizure:

**** Please complete required information on page 2 for SEIZURE patients** **** See Page 2 for list of precautions and contraindications**

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR PATIENTS WITH DOWN SYNDROME

For those with Down Syndrome: Neurologic Symptoms of Atlantoaxial Instability

Present ☐

Absent ☐

I have reviewed the attached list of conditions which may present precautions and contraindications to therapeutic horseback riding on page 2, to my knowledge there is no reason why this person cannot participate in supervised equestrian activities:

Physician's Signature:	**Date of EXAM:**
Physician's Name (please print):	**Physician's Phone:**
Address:	**Physician's FAX:**

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Client Medical History & Physicians' Statement
(PAGE 2 OF 2)

SEIZURE DISORDER PARTICIPANTS

PATH, Int'l recommends the following information for PATH Operating Centers for riders with seizure disorders.

Would you consider _____'s seizures to be:

☐ Completely controlled ☐ Very well controlled ☐ Fairly controlled by medication

Type of seizure:	
Typical aura:	
Typical motor activity during seizure:	
Description of client's behavior during post-ictal state:	Post-ictal state duration:
Specific directions as to what to do if a seizure should occur at Heroes on Horseback:	
Physician's Signature	Date:

INFORMATION FOR PHYSICIAN

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

ORTHOPEDIC
Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization
Disease

NEUROLOGIC
Hydrocephalus/shunt
Spina bifida
Tethered Cord
Chiari Malformation
Hydromyelia
Paralysis due to Spinal Cord Injury
Seizure Disorders

SECONDARY CONCERNS
Behavior Problems
Age under 2 years
Age 2 - 4 years
Acute exacerbation of chronic disorder
Indwelling catheter

MEDICAL/SURGICAL
Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident

HEROES ON HORSEBACK
Bluffton, South Carolina
Phone (843) 757-5607

GENERAL ACTIVITY RELEASE, ASSUMPTION OF RISK and WAIVER OF LIABILITY AGREEMENT

This document waives important legal rights. Read it carefully before signing.

I **AGREE** for myself, and/or my child, my/our administrators and assigns, in consideration for my, and/or my child's participation in Heroes on Horseback activity of the following:

I **AGREE** that I choose to participate voluntarily in Heroes on Horseback activities as a rider, handler or spectator. I am fully aware and acknowledge that horse sports and Heroes on Horseback activities involve inherent dangerous risks of accident, loss, and serious bodily injury including, but not limited to, broken bones, head injuries, trauma, pain, suffering or death ("Harm"). I fully understand that this release covers, but is not limited to, inherent risks of an equine activity which mean a danger or condition that is an integral part of an equine activity, including but not limited to, any of the following:

- The propensity of an equine to behave in ways that may result in injury, death, or loss to persons on or around the equine;
- The unpredictability of an equine's reaction to sounds, sudden movement, unfamiliar objects, persons, or other animals;
- Hazards, including, but not limited to, surface or subsurface conditions;
- A collision with another equine, another animal, a person, or an object;
- The potential of an equine activity participant to act in a negligent manner that may contribute to injury, death, or loss to the person of the participant or to other persons, including but not limited to, failing to maintain control over an equine or failing to act within the ability of the participant.

I **AGREE** that I/my child/my ward would like to participate in the Heroes on Horseback program. I acknowledge the risks and potential risks, however, I feel that the possible benefits to me/my child/my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors or administrators waive and release forever all claims for damages against Heroes on Horseback, its Board of Directors, instructors, therapists, aides, volunteers, employees, facility owners, NCM Equestrian LLC and affiliated organizations for any and all injuries and/or losses I may sustain while participating in the Heroes on Horseback program including activities occurring outside of the scope of the program itself, including, but not limited to transportation, care giving, horse exercising etc.

By signing below, I **ACKNOWLEDGE** that I enter into this release after having read the same, and place my signature hereto of my own free voluntary act and deed. By signing below, I represent to Heroes on Horseback that I fully understand its contents, that I do not need any further explanation, and I waive any further explanation.

I **AGREE** to assume all risks of Harm to me and/or my child, and **specifically agree to the SOUTH CAROLINA LIABILITY LAW** regarding equine/ farm animal activity liability: **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, Code of Laws of South Carolina, 1976.**

ACCEPTED BY: (if under the age of 18 years old, there must be a legal guardian signature below)

PARTICIPANT Signature / Legal Guardian Signature(s):	**VOLUNTEER Signature / Legal Guardian Signature(s):**
Print Participant Name / Legal Guardian Name(s): **DATE:**	**Print Volunteer Name / Legal Guardian Signature(s):** **DATE:**