



Return forms to: Mountin' Hopes
P.O. Box 387
Mars Hill, NC 28754
Telephone: (828) 689 2291
E-mail: volcoord@mountinhopes.org

RIDER'S REGISTRATION AND RELEASE FORM

REGISTRATION

Registration form fields: RIDER'S NAME, DATE OF BIRTH, AGE, STREET, CITY, STATE, ZIP, PHONE, E-MAIL ADDRESS, PARENT(S) OR GUARDIAN(S), ADDRESS IF DIFFERENT FROM ABOVE, HOME PHONE IF DIFFERENT FROM ABOVE, E-MAIL, EMPLOYER(S): FATHER, MOTHER, WORK PHONE(S): FATHER, MOTHER

TWO EMERGENCY CONTACTS DIFFERENT FROM THE PHONE NUMBERS ABOVE:

Emergency contact fields: NAME, PHONE

LIABILITY RELEASE

Warning: Under North Carolina 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 exclusively from the inherent risks of equine activities.

I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/my son/my daughter/my ward/ are greater than the risk assumed.

Date Signature

PHOTO RELEASE

I hereby consent to and authorize the use and reproduction by Mountin' Hopes of any and all photographs and any other audiovisual materials taken of me/ my son/ my daughter/ my ward for promotional material, educational activities or for any other use for the benefit of the program.

Date Signature



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PO Box 387  
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**Phone:** 828-689-2291  
**E-mail:** [volcoord@mountinhopes.org](mailto:volcoord@mountinhopes.org)

## RIDER'S INFORMATION

Rider's Name: \_\_\_\_\_ Date: \_\_\_\_\_

TO BE COMPLETED BY PARENT, CAREGIVER, OR THERAPIST

PLEASE INCLUDE ANY OTHER INFORMATION, WHICH WOULD BE HELPFUL. **THIS IS IMPORTANT. IT WILL HELP INSTRUCTORS WITH YOUR RIDER, SO PLEASE BE AS CANDID AS POSSIBLE.** USE THE BACK OF THIS FORM OR ADDITIONAL SHEETS IF NEEDED.

Long-term therapeutic goals (5 years +):

Short-term therapeutic goals (within one year):

Specific activities/exercises being used to achieve these goals in addition to therapeutic riding:

Rider's likes, dislikes, interests, and hobbies:

Behaviors to be encouraged:

Behaviors to be discouraged:

Behavior patterns which may affect our work with this rider, for example, does he/she get along well with others, does he/she have any sensory issues, does he/she have any sensitivity to extreme temps, any allergies or fears:

Does this rider have ANY history of unsafe behavior or offenses with self or towards other people, animals or property? IF so please describe and complete a behavior management form.

What is the most effective method used in communicating with this rider, and how does he/she communicate with others:

What could we help your rider with the most? What would you like to be his/her greatest improvement?

Who else is involved in your rider's care besides their physician; list ALL professionals with the ability to provide care for your rider:

Name of person completing this form \_\_\_\_\_

Relationship to rider: \_\_\_\_\_ Telephone: \_\_\_\_\_



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**RIDER'S CONSENT FOR RELEASE OF INFORMATION  
FROM OTHER PERSONS OR FACILITIES INVOLVED IN THE CARE OF YOUR RIDER**

I HEREBY AUTHORIZE \_\_\_\_\_  
(PLEASE PRINT FULL NAME)

**THEIR ADDRESS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TO RELEASE INFORMATION FROM THE RECORDS OF \_\_\_\_\_  
(RIDER'S NAME)

TO MOUNTIN' HOPES, FOR THE PURPOSE OF DEVELOPING A THERAPEUTIC RIDING PROGRAM FOR THE ABOVE NAMED STUDENT. THE INFORMATION TO BE RELEASED IS MARKED BELOW.

- \_\_\_ PHYSICAL THERAPY EVALUATION, ASSESSMENT, AND PROGRAM PLAN
- \_\_\_ OCCUPATIONAL THERAPY EVALUATION, ASSESSMENT, AND PROGRAM PLAN
- \_\_\_ SPEECH THERAPY EVALUATION, ASSESMENT, AND PROGRAM PLAN
- \_\_\_ PSYCHOLOGICAL THERAPY EVALUATION, ASSESSMENT, AND PROGRAM PLAN
- \_\_\_ CLASSROOM INDIVIDUAL EDUCATION PLAN (I.E.P.)
- \_\_\_ MEDICAL HISTORY
- \_\_\_ OTHER \_\_\_\_\_

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_  
(CLIENT, PARENT, OR GUARDIAN)



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**RIDER'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
 HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ DATE OF LAST TETANUS SHOT \_\_\_\_\_  
 DIAGNOSIS \_\_\_\_\_ DATE OF ONSET \_\_\_\_\_

<b>FOR PERSONS WITH DOWN SYNDROME</b>	<b>YES</b>	<b>NO</b>	<b>DATE</b>
Negative cervical x-ray for atlantoaxial instability			
Negative for clinical symptoms of atlantoaxial instability			

Please indicate whether rider has a problem and/or has had surgeries in any of the following areas by checking

**YES** or **NO**. If **YES**, please comment. **This form must be completed by your health care provider.**

	<i>YES</i>	<i>NO</i>	<i>Comments</i>
<b>SEIZURES</b>			
			Are they controlled?
<b>MEDICATIONS</b>			
<b>AUDITORY</b>			
<b>VISUAL</b>			
<b>SPEECH</b>			
<b>CARDIAC</b>			
<b>CIRCULATORY</b>			
<b>PERIPHERAL VASCULAR</b>			
<b>VARICOSE VEINS</b>			
<b>HEMOPHILIA</b>			
<b>HYPERTENSION</b>			
<b>SERIOUS HEART CONDITION</b>			
<b>STROKE</b>			
<b>NEUROLOGICAL</b>			
<b>HYDROCEPHALUS/SHUNT</b>			
<b>SPINA BIFIDA</b>			
<b>TETHERED CORD</b>			
<b>CHIARI II MALFORMATION</b>			
<b>NEUROLOGIC (cont.)</b>			

HYDROMELIA-Paralysis due to spinal injury			
<i>ORTHOPEDIC:</i>			
SPINAL FUSION			
SPINAL INSTABILITIES			
SPINAL ABNORMALITIES			
SCOLIOSIS			
KYPHOSIS			
HIP SUBLUXATION			
HIP DISLOCATION			
OSTEOPOROSIS			
PATHOLOGIC FRACTURES			
COXAS ARTHROSIS			
HETEROTOPIC OSSIFICATION			
OSEOGENESIS IMPERFACTA			
CRANIAL DEFECTS			
SPINAL ORTHOSIS			
<i>INTERNAL SPINAL STABILIZING DEVICES</i>			
LEARNING DISABILITIES			
MENTAL			
PSYCHOLOGICAL			
ALLERGIES			
CANCER			
POOR ENDURANCE			
RECENT SURGERY			
DIABETES			
INDWELLING CATHERTER			
INDEPENDENT AMBULATION			
CRUTCHES			
BRACES			
WHEELCHAIR			
PULMINARY			
MUSCULAR			
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 weight the medical information above against the existing precautions and contradictions. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, LPC, etc.) in the implementation of an effective equestrian program.**

Physician's name (please print) \_\_\_\_\_ Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

