UPWARD TRANSITIONS THERAPEUTIC HORSEMANSHIP
at Esperanza Farm, 12037 F.M. 1560, Helotes, TX 78023 972-977-3833

RIDER REGISTRATION

THIS REGISTRATION FORM IS FOR (check one

❑Student ❑Student's parent

❑Student's guardian ❑Student's caregiver

Office use only	
START DATE	
3 YR MEDICAL REVIEW DATE	

Check one: ❑ Mrs. ❑ Ms. ❑ Mr.

Name: _____ **Today's Date:** _____
Last name, First name, Initial

Address: _____ **Birth Date:** _____

City/ST/Zip: _____

Cell: ( ) _____ Work: ( ) _____ Home: ( ) _____

E-mail address: _____

If minor (under 18) or a dependent adult please provide the following information:

Parent/Guardian/Caregiver name: _____ Home or Cell: ( ) _____

Address/City/State/Zip: _____
(If different from above)

Photo Release - I authorize UTTH to use any and all photographs or any other audio/visual materials taken of me (or my child/ward) for promotional, educational activities, exhibitions or for any other use for the benefit of the program.

Consent signature_____ **I do not consent**_____.

Adult or Parent/Guardian/ Caregiver, signed in the presence of center staff

Medical Emergency - In the event emergency medical aid or treatment is required due to illness or injury during the process of receiving services or while being on the property of UTTH I authorize UTTH to secure and retain medical treatment and transportation if needed. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment. This 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(s) named below is unable to be reached. *If you do not consent, please provide written information on your desired procedures in case emergency medical aid/treatment is needed.*

Consent signature_____ **I do not consent**_____.

Adult or Parent/Guardian/ Caregiver, signed in the presence of center staff

In the event of an emergency please contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____

Emergency information: Nearest medical facility is assumed if no information is entered.

Physician's Name: _____ City:_____

Preferred Medical Facility: _____

Health Insurance Company: _____ Policy # _____

Allergies to medications: _____

Current medications: _____

Parents and School group personnel Please check <u>one</u> of the following:

_____ I am a Parent/Guardian/Caregiver and will be available when (name)_____ is riding.

_____ I will be here with (name of school / organization) _____

Parents/Guardians please check any areas of interest:

❏ Public Relations ❏ Photography/Video ❏ Fundraising

❏ Budget & Finance ❏ Special Olympics ❏ Future Planning

❏ Newsletter ❏ Facility Repairs

❏Program Special Events Administration

This space is for the yearly update of information by the person named above.

Gray areas are Office use only

Yearly review	Date	Signature
1st year review		
2nd year review		
3rd year review		

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Name:_____ Minor _____ Adult _____

I, _____ (and my minor child or ward)_____)

("I/We"), would like to participate in activities of Upward Transitions Therapeutic Horsemanship ("UTTH"). In consideration of allowing me /my child/my ward to come on the premises, to be near horses, to handle and to ride a horse, and on behalf of myself, my child, or our personal representatives, heirs, next-of-kin, spouses and assigns, I agree to the following.

1. I fully understand and acknowledge that horsemanship activities, or being in close proximity to a horse is an inherently dangerous activity and involves risks that may cause serious injury, including permanent disability, paralysis, or death because of the unpredictable nature of horses, regardless of their training or past performance; or because of my own, my child or ward's actions or inactions, those of others participating in the event, or the conditions in which the event takes place; and that there may be other risks either not known to me or not readily foreseeable at this time.

2. I voluntarily assume the risk and danger of injury or death inherent in the horsemanship activities or being in close proximity to a horse or on the premises of the stable or the failure to wear a protective helmet when riding a horse, and use of saddles, bridles, equipment, and/or other gear.

3. I **WAIVE AND FOREVER RELEASE, ACQUIT, DISCHARGE AND PROMISE NOT TO SUE** UTTH, its board of directors, trustees, agents, instructors, therapists, employees, representatives, volunteers, owners of property on which UTTH operates, successors or assigns (each considered one of the "Releasees" herein) from all liability, claims for any loss, damages, demands, personal damages known or unknown, injury (including death), or cost to me / my child/my ward arising out of the horsemanship activities at UTTH.

4. I **RELEASE** UTTH from any claim that UTTH was negligent in connection with my or my child's riding a horse including but not limited to training or selecting horses, maintenance, care, fit or adjustment of saddles or bridles, instruction on riding skills or leading and supervising riders or the use of any equipment provided by UTTH or being on the premises of the Stable, which resulted in loss, damage, injury or death.

5. I agree that if, despite this release, waiver of liability, and assumption of risk I, or anyone on my and/or my minor child's behalf, makes a claim against any of the Releasees, I will **INDEMNIFY, DEFEND, AND HOLD HARMLESS** each of the Releasees from any loss, liability, damage, or cost which any may incur as the result of such claim.

6. I agree to abide by and follow any instructions given or rules established by UTTH or any of its employees or volunteers with regard to my or my child's participation in the horsemanship activities at UTTH.

7. I understand that UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTICE & REMEDIES CODE) A FARM ANIMAL PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN FARM ANIMAL ACTIVITIES RESULTING FROM THE INHERENT RISKS OF FARM ANIMAL ACTIVITIES.

8. I expressly agree that the foregoing assumption of risk, release and waiver of liability and indemnity agreement is intended to be as broad and inclusive as is permitted by the law of the State of Texas and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

I have read this document. I understand it is a promise not to sue and to release and indemnify UTTH, the Stable, its owners, employees and agents for all claims. I have made a free and deliberate choice to sign the Release and Waiver as a condition to UTTH allowing me or my child to ride or handle a horse or to be in the close proximity of a horse. I have concluded that the risks involved and the Release and Waiver of Liability is worth the expected benefits of therapeutic horse related activities and I acknowledge that the same is valuable consideration for this Release and Waiver of Liability.

_____ _____

Printed name of participant Signature of Participant (if age 18 or over)

Date:_____ _____

Signature of Parent/Legal Guardian(if participant under age 18)

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Three annual reviews before renewal	
Date	Initials

Participant's Medical History and Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____City/ST/ZIP _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs: _____

Mobility: Independent Ambulation Y N Assisted Ambulation Y & Wheelchair Y N

Describe any braces or assistive devices _____

For those with Down Syndrome: **AtlantoDens Interval X-rays, date: _____ Result: + or — Neurologic**

Symptoms of AtlantoAxial Instability: _____

Please indicate current or past special needs in the following systems/areas

Systems/Areas	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not precluded from participation in equine-assisted activities. I understand that the PATH Intl. center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Doctor's Signature: _____ Date: _____

Phone: ( )_____ License/UPIN &umber: _____

Address: _____ City/ST/ZIP _____