Best of Friends

(Therapeutic Riding Program)

Medical Form and Application (Required)

MEMBER: Name:_____ Date of Birth: _____

Address:_____

_____

Parents Name(s) and Address if different than above:

_____

_____

Telephone:_____ _____

Riding Experience:

Have you previously ridden a horse or participated in any type of horseback riding activity?

No____

Yes____ Please list program and dates_____

Riding Date Preference:

Which riding class do you prefer:

Saturday mornings _____ Please specify what time (between 9:30 a.m. and 1 p.m)

Do you plan on participating in the whole Saturday program (March – Nov.)? ____
If NO, then indicate what time frame you plan on participating_____

Monday afternoons _____ Please specify what time (between 1:30 p.m. and 3:30 p.m.)

PLEASE Return COMPLETED Form (all 5 pages) to *Best of Friends*, P.O. Box 94, Johnstown, PA 15907

MEDICAL HISTORY

Date:_____

NAME:_____DOB_____AGE_____

SEX_____HEIGHT_____WEIGHT_____PULSE_____B.P._____

DIAGNOSIS_____

CAUSE:_____

MEDICATIONS (Type, Purpose, Dose):_____
Atlanto-Axial Instability? Yes_____No_____

Cervical X-Ray for Atlanto-Axial Instability: Positive_____Negative_____X-Ray Date_____

Tetanus Shot: Yes_____ No_____ Date_____

Please indicate if client has or has a history of the following secondary problems by checking yes or no. If YES, please include COMPLETE information pertaining to the problem.

PROBLEM	YES	NO	IF YES, OR HISTORY OF, DESCRIBE
AUDITORY IMPAIRMENT	____	___	_____
LEARNING DISABILITY	____	___	_____
MENTAL IMPAIRMENT	____	___	_____
PSYCHOLOGICAL IMPAIRMENT__		___	_____
SPEECH IMPAIRMENT	____	____	_____
VISUAL IMPAIRMENT	____	____	_____
ALLEGIES	____	____	_____
CARDIAC	____	____	_____
CIRCULATORY PVD	____	____	_____
Postural Hypotension	____	____	_____
Hemophilia	____	____	_____
PULMONARY	____	____	_____
Asthma/COPD	____	____	_____
NEUROLOGICAL	____	____	_____
Seizures	____	____	_____
Controlled	____	____	_____
Last Seizure: _____	____	____	_____
Hydrocephalus	____	____	_____
Shunt	____	____	_____
Sensory Loss	____	____	_____
Pain	____	____	_____
MUSCULAR	____	____	_____
Contractures	____	____	_____

PROBLEM	YES	NO	IF YES, OR HISTORY OF, DESCRIBE
SKELETAL			
Spinal Column Injury	____	____	_____
Subluxing Joints	____	____	_____
Dislocating Joints	____	____	_____
Laminectomy/Fusion	____	____	_____
Scoliosis-Degree/Type/Brace	____	____	_____
Last X-Ray			_____
Kyphosis/Lordosis			
Degree/Type	____	____	_____
Spondylolisthesis	____	____	_____
Spinal Abnormality	____	____	_____
Osteoporosis	____	____	_____
Heterotrophis Ossification	____	____	_____
Joint Disease	____	____	_____
Cranial Defects	____	____	_____
Fractures	____	____	_____
Other_____	____	_____	_____

MEDICAL HISTORY

Please indicate any medical problems not indicated above.

Please indicate special precautions.

MOBILITY STATUS

Ambulatory? Yes_____ No_____

If No, describe:_____

PROSTEHETICS/ORTHODONTICS:

Type:_____Purpose:_____

Type:_____Purpose:_____

Please describe any other additional information that might help us to work with this student.

PHYSICIAN STATEMENT:

Horseback Riding is an appropriate activity for the above named person.

Physician's Signature:_____

Physician's NAME (Please Print):_____

Physician's Address:_____

Telephone:_____

REGISTRATION AND RELEASE FORM

REGISTRATION

Client_____DOB_____ Age_____

Street_____City_____State/ZIP Code_____

Parents or Guardian_____

Address_____City_____State_____

Zip Code_____Home Phone_____ Work/Emergency Phone_____

School or institution presently attending:_____

In case of emergency contact:_____Phone_____

LIABILITY RELEASE

_____(Client Name) would like to participate in the 20__ _____ *Best of Friends* program. 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. 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 *Best of Friends* Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward/may sustain while participating in horseback riding or other activities with *Best of Friends.*

Date:_____ Signature:_____
Client, Parent, or Guardian

ACKNOWLEDGEMENT OF RULES AND RESPONSIBILITY

I have read and AGREE to abide by RULES as stated by *Best of Friends* for horseback riding as well as during the time that I am located on the premises for such activity. I have consulted with my child's health care professional(s) and determined there are no contraindications for participation of my child in *Best of Friends* horse activities.

Date:_____Signature:_____
Client, Parent, or Guardian

PHOTO RELEASE: (OPTIONAL)

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

Date:_____Signature:_____
Client, Parent or Guardian

GOALS to be worked on during Year

Please list any and all GOALS that should be worked on during the coming year:

Information contained herein will be maintained in confidence and is required for the safety and continued development of the *Best of Friends* therapeutic riding program.

Please return completed form (all 5 pages) to:

***Best of Friends*, P.O. Box 94, Johnstown, PA 15907-0094**