O.A.T.S.

Offering Alternative Therapy with Smiles, Incorporated

~ horseback riding for the disabled ~

PREMIER ACCREDITED CENTER
PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Rider's Registration and Release Form

If filling this out by hand, please print legibly, using blue or black ink.

Rider's Name:	Birth date:	☐M ☐F
Street Address:		
City/State/Zip:		
Home Phone:	Cell:	Work :
Email Address:		
School/Institution Presently Attending:		

Guardian/Caregiver Information

☐Parent or ☐Guardian (if under 18):		
Address, if different from above:		
1st Emergency Contact:	Cell:	Work:
2nd Emergency Contact:	Cell:	Work:
Caregiver:	Cell:	Other:

Michigan Equine Activity Liability Act Warning

Participant's Full Name:	Date:

I UNDERSTAND THAT UNDER THE MICHIGAN EQUINE ACTIVITY LIABILTY ACT, AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJRY TO OR DEATH OF A PARTICIPANT IN AN EQUINE ACTIVITY RESULTING FROM AN INHERENT RISK OF EQUINE ACTIVITY.

Signature:
(Parent or Guardian, if under 18):

Name of Signatory:

General Liability Release

I, choose to participate in the *O.A.T.S. hrh* riding program. I acknowledge the risks and dangers together with potential risks and dangers of horseback riding. However, I think that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I have read the warning mandated by the Michigan Equine Activity Liability Act. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors, administrators or personal representatives, waive and release forever all claims for damages against O.A.T.S. hrh, its Board of Directors, Instructors,Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/myson/my daughter/my ward may sustain while participating in O.A.T.S. hrh activities or upon O.A.T.S. hrh premises.

Signature: (Parent or Guardian, if under 18)	Date:

Name of Signatory:

Revised 6/6/15

Photo Release

I hereby consent to and authorize the use and reproduction by O.A.T.S.hrh of any and all photographs and any other audio/visual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities or any other use for the benefit of O.A.T.S.hrh programs. ☐ Yes ☐ No

Signature:
(Parent or Guardian, if under 18): Date:

Authorization for Emergency Medical Treatment

*You **must** sign either "Consent Plan" or "Non-Consent Plan"*

In the event that emergency medical aid and/or treatment is required due to illness or injury, during the process of receiving services, while volunteering or while being on the premises of O.A.T.S.hrh, I authorize O.A.T.S.hrh :

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

Emergency Contact:	Phone:
Secondary Emergency Contact:	Phone:
Physician's Name:	Phone:
Preferred Medical Facility:	
Health Insurance:	Policy Number:

☐ CONSENT – I DO give my consent for emergency medical treatment. This authorization includes x-ray, surgery, hospitalization, medication and any treatment or procedure deemed "life saving" by the physician. This provision will only be invoked if the person listed below is unable to be reached.

Name:	Phone:
Address:	
City, State, Zip	

Signature:
(Parent or Guardian, if under 18) Date:

☐ NON-CONSENT - I DO NOT give my consent for emergency medical aid and/or treatment in case of illness or injury during the process of receiving services, while volunteering or while being on the premises of O.A.T.S.hrh. In the event that emergency treatment or aid is required, I wish the following to take place: (please fill in your express directions:)

Signature:
(Parent or Guardian, if under 18): Date:

Class Cancellation Notification

In the rare event that a class or event must be cancelled, for which you are scheduled to volunteer, we will text or eMail you.

Cell phone #

Cell phone company: AT & T ☐ Sprint ☐ T-Mobile ☐ Verizon ☐ Other :

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O.A. T.S.hrh
4920 Groveland Rd
Ortonville, MI 48462
248-245-1020 www.oatshrh.org -
WalkOnOats@gmail.com

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Medical History and Physician's Release Form – Must be filled out by a Physician

Name:		Birth date:	
Street Address:		Ht:	Wt:
City/State/Zip:			
Name of ☐ Parent or ☐ Guardian			
Address, if different from above:			
Primary Diagnosis:		Date of Onset:	
Seondary Diagnosis:		Date of Onset:	
Seizuree Type:	Controlled?	Date of last Seizure:	

AREAS	YES	NO	COMMENTS
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Incontinence			
Coordination			
Balance			
Independent Ambulation	Crutches: ☐ yes ☐ no	Braces: ☐ yes ☐ no	Wheelchair: ☐ yes ☐ no
Special Precautions/Needs:			

Participants with Downs Syndrome – Please Note & Complete

Due to the nature of the activity of horseback riding, no individual diagnosed with Down Syndrome can be accepted for riding instruction without proof of a negative diagnostic x-ray for Atlantoaxial Instability. Please provide the following information:

Most recent cervical x-ray for AAI: ☐ Positive ☐ Negative Date of last x-ray:

Annual cervical exam for AAI: ☐ Positive ☐ Negative Date of last exam:

Patient's Initials_____

Physician's Findings

The following conditions, if present, may represent precautions and contraindications to therapeutic horse riding. Please be sure to clearly identify and check the boxes if any of the following conditions are present and explain to what degree.

Orthopedic		**Medical / Surgical**	
Atlantoaxial Instabilities		Allergies	
Coxas Arthrosis		Cancer	
Cranial Deficits		Diabetes	
Heterotopic Ossification		Hemophilia	
Hip Subluxation and Dislocation		Hypertension	
Internal Spinal Stabilization Devices		Peripheral Vascular Disease	
Kyphosis		Poor Endurance	
Lordosis		Recent Surgery	
Osteogenesis Imperfecta		Serious Heart Condition	
Osteoporosis		Stroke (Cerebrovascular Accident)	
Pathologic Fractures		Varicose Veins	
Scoliosis			
Spinal Fusion			
Spinal Instabilities/ Abnormalities			
Spinal Orthoses		**Neurologic**	
		Chiari II Malformation	
Secondary Concerns		Hydrocephalus/shunt	
Acute exacerbation of chronic disorder		Hydromyelia	
Age two - four years		Paralysis due to Spinal Cord Injury	
Behavior problems		Seizure disorders	
Indwelling catheter		Spina Bifida	
Integumentary/Skin		Tethered Cord	

Please print or stamp your name, SIGN & DATE - Thank You

To my knowledge, there is NO REASON why this person cannot participate in supervised equestrian activities. However, I understand that the final decision regarding acceptance rests with the Freedom Ride, Inc. staff, upon due consideration of the participant's special needs, precautions and contraindications, and the safety of the participant, staff, volunteers and horses.

Physician Name:	Pnone:
Signature:	**Date:**
Address:	
Additional Comments:	