STUDENT FORMS

FORM NAME	UPDATE SCHEDULE	
	ANNUALLY	BI-ANNUALLY
Rider Information	x	
Authorization for Emergency Medical Treatment	x	
Release & Hold Harmless Agreement	x	
Photo Release	x	
Cancellation Policy Acknowledgement	x	
Possible Reasons for Termination of Services	x	
Medical History & Physician Release *****unless otherwise indicated on form		x*****

RIDER INFORMATION FORM

Participants Name (print): ____________ **Date of Birth:** ____________

Parent/Legal Guardian Name (if Participant is under 18): ____________

Relationship to Participant (if applicable): ____________

CONTACT INFORMATION

Phone #: ☐ **Cell:** ____________ ☐ **Home:** ____________ ☐ **Work:** ____________

Email Address: ____________

Address: ____________ **City:** ____________ **Zip Code:** ____________

Emergency Contact: ____________ **Phone:** ____________

DEMOGRAPHIC INFORMATION

Participant Gender: ____________ **Height:** ____________ **Weight:** ____________

Diagnosis: ____________ **Date of Onset:** ____________

Is Participant Currently Employed or In School? ☐ **Yes** ☐ **No**

☐ **Employed** **Employer Name:** ____________

☐ **In School** **School Name:** ____________ **Grade:** ____________

HEALTH INFORMATION

Relevant Health History:

Recent Changes in Health:

Current Medications:

Precautions/Restrictions:

ADDITIONAL CONTACT INFORMATION

Please list contact information for any parties who are responsible for the participant, or who may be involved in coordinating lesson schedules:

Name: ____________________ **Relationship to Participant:** ____________________

Phone #: ____________________ **Email Address:** ____________________

Name: ____________________ **Relationship to Participant:** ____________________

Phone #: ____________________ **Email Address:** ____________________

Signature: ______________________________ **Date:** ____________________

Print Name: ______________________________

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Participants Name (print): ____________________ **Date of Birth:** ____________

Parent/Legal Guardian Name (if Participant is under 18): ____________________

Relationship to Participant (if applicable): ____________________

Phone #: ☐ **Cell:** ____________ ☐ **Home:** ____________ ☐ **Work:** ____________

IN THE EVENT THAT I CANNOT BE REACHED:

Emergency Contact: ____________________ **Phone:** ____________

Alternate Contact: ____________________ **Phone:** ____________

Physician's Name: ____________________ **Phone:** ____________

Preferred Medical Facility: ____________________ **Phone:** ____________

Health Insurance Company: ____________________ **Phone:** ____________

List all pertinent medical information (allergies to food or drugs, medications being taken, special medical conditions, etc):

CONSENT PLAN:

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while on the property of the agency, I authorize the **Crossing Bridges Therapeutic Riding Center** 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 listed is unable to be reached.

Consent Signature: ____________________ **Date:** ____________

Print Name: ____________________

Relationship to Participant: ____________________

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 **Crossing Bridges Therapeutic Riding Center**. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Non-Consent Signature: ______________________________ **Date:** ______________

Print Name: ______________________________

Relationship to Participant: ______________________________

RELEASE & HOLD HARMLESS AGREEMENT

Participants Name (print): ______________________________

Parent/Legal Guardian Name (if Participant is under 18): ______________________________

Relationship to Participant (if applicable): ______________________________

The program at the **Crossing Bridges Therapeutic Riding Center** (TRC) located at **6377 Monument Drive, Grants Pass, Oregon 97526**; provides therapeutic horseback riding for able-bodied and disabled children and adults. Volunteers and horses are carefully selected and trained and safety equipment is required for all riders since horseback riding is a risk exercise.

No student will be accepted for riding instruction and no volunteer accepted for service until this form has been **read, understood, completed** and **signed** by the parent(s), caregivers(s) and/or guardian(s) of a minor, or if the student or volunteer is of legal age and sound mind, by the student or volunteer.

Although participation in the program is under strict supervision and every effort is made to avoid injury or accident, the undersigned acknowledges the inherent risks involved in riding and working around horses. This includes bodily injury from horseback riding or being in close proximity to horses. Among other risks, both horse and rider can be injured in normal use or in competition and schooling. In order to provide this valuable service, **no liability** can be accepted by the **Crossing Bridges TRC,** located at **6377 Monument Drive, Grants Pass, Oregon 97526** or any of the organizations or persons connected with the above-named facility.

In Consideration, for the privilege of riding and/or working around horses at the **Crossing Bridges TRC**, the undersigned, as self, or as parent(s) or guardian(s) of the undersigned minor, jointly and severally, do hereby agree to release, hold harmless and indemnify the **Crossing Bridges TRC**, its officers, directors, trustees, agents, employees, representatives, successors and assigns, from all manner of liability, loss, costs, claims, demands and damages of every kind and nature whatsoever, including but not limited to reasonable attorney's fees, which the undersigned or said minor may now or in the future have against the **Crossing Bridges TRC,** its officers, directors, trustees, agents, employees, representatives, successors and assigns, on account of any accident, damage, injury or illness, physical or mental condition, known or unknown, to the undersigned or said minor, or the treatment thereof, arising as a result of, or in any way connected to acts or incidents occurring at or relating to the **Crossing Bridges TRC,** its officers, directors, trustees, agents, employees, representatives, successors or assigns, including but not limited to their negligence or gross negligence in rendering the services described above or in any way incidental thereto.

Signature: ______________________________ **Date:** ______________

PHOTO RELEASE

Participants Name (print): ______________________________

Parent/Legal Guardian Name (if Participant is under 18): ______________________________

Relationship to Participant (if applicable): ______________________________

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to the **Crossing Bridges Therapeutic Riding Center** (TRC) permission to take, or have taken, still and moving photographs and films, including television pictures, of ______________________ *[participants name]* and consents and authorizes the **Crossing Bridges TRC** to use and reproduce the photographs, films and pictures and to circulate and publicize the same by all means including, but not limited to, newspapers, television media, brochures, pamphlets, instructional material, books and clinical material.

With respect to the foregoing matters, no inducements or promises have been made to me/us to secure my/our signature(s) to this release other than the intention of the **Crossing Bridges TRC** and its work.

Signature: ______________________________ **Date:** ______________________

CANCELLATION POLICY ACKNOWLEDGMENT

Participants Name (print): ______________________________

Parent/Legal Guardian Name (if Participant is under 18): ______________________________

Relationship to Participant (if applicable): ______________________________

Your appointment is very important to the **Crossing Bridges Therapeutic Riding Center** (TRC) team, it is reserved especially for you. We understand that sometimes schedule adjustments are necessary; therefore, we respectfully request at least 24 hours' notice for cancellations.

Please understand that when you forget or cancel your appointment without giving enough notice, we miss the opportunity to fill that appointment time, and clients on our waiting list miss the opportunity to receive services. If an appointment is missed, canceled or changed with less than 24 hours' notice, payment for the lesson will be expected in full.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for **Crossing Bridges TRC** as described above.

Thank you for your understanding and cooperation.

Signature: ______________________________ **Date:** ______________

POSSIBLE REASONS FOR TERMINATION OF SERVICES

Participants Name (print): ______________________________

Parent/Legal Guardian Name (if Participant is under 18): ______________________________

Relationship to Participant (if applicable): ______________________________

Please be advised of the following reasons that may lead to discharge from the therapy program and/or from the **Crossing Bridges Therapeutic Riding Center** (TRC). It is determined at the time of discharge from the therapy program, options to transfer to sport riding program or the possible discharge from the **Crossing Bridges TRC** entirely.

- Participant has reached all their goals!
- Participant's potential to maintain head and neck control in sitting presents a safety concern.
- Inability to follow directions is interfering with progress toward treatment goals.
- Uncontrolled and/or inappropriate behavior that constitutes a safety risk to participant and/or staff.
- Participant exceeds weight that can safely be managed by staff, volunteers, and/or therapy horses.
- Any change in the participant's medical, physical, cognitive, or emotional condition that makes therapeutic riding inappropriate.
- Three scheduled sessions are missed without prior canceling, at the discretion of the head instructor.
- Non-payment of billed funds after 90 days.

Signature: ______________________________ **Date:** ______________