CROSSING BRIDGES
Therapeutic Riding Center
6377 Monument Drive | PO Box 2276
Grants Pass, OR 97528

January 1, 2021

Hi Everyone,

In an effort to make sure we are in compliance with our PATH Certification as a Therapeutic Riding Center, as well as make sure we are providing the most relevant and useful services to our students, we will be having our student forms updated on an annual basis. We understand this is a lot of information to complete and review, but the forms contain information that can change on a regular basis, including emergency contact information, medications, relevant health information, and restrictions we should be considering.

Please complete the following set of forms and return to me by **January 31, 2021**:

> > Rider Information & Parent | Guardian Information
> > Authorization for Emergency Medical Treatment
> > Release & Hold Harmless Agreement
> > Photo Release
> > Possible Reasons for Termination of Services
> > Cancellation Policy
> > Medical History/Physician Release **(separate document)**

I appreciate your help in allowing us to continue to provide exceptional services to our students that meet their current needs.

Sincerely,

Jennifer Clark

Jennifer Clark, Executive Director

RIDER INFORMATION

Name of Participant _____ **E-mail** _____

Parents/Guardian and/or Caregiver (if applicable) _____

Address _____ **City** _____ **Zip** _____

Home Phone # _____ **Cell Phone #** _____ **Other** _____

Emergency Contact _____ **Phone** _____

Participant Occupation/School and Level _____

Participant DOB _____ **Gender** M or F **Height** _____ **Weight** _____

Diagnosis _____ **Date of Onset** _____

Relevant Health History _____

_____

_____

Recent Changes in Health _____

_____

_____

Medications (Current) _____

_____

_____

Precautions/Restrictions _____

_____

_____

PARENT | GUARDIAN INFORMATION

Father's Name _____ **Phone** _____

Father's Employer _____ **Phone** _____

Mother's Name _____ **Phone** _____

Mother's Employer _____ **Phone** _____

_____ _____

Signature of Parent, Participant, Caregiver or Guardian **Date**

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Print Participant Name _____ **Date of Birth** _____

Print Parent/Guardian/Caregiver Name (If Applicable) _____

Street Address _____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Work Phone** _____

In The Event I Cannot Be Reached:

Contact _____ **Phone** _____

Alternate Contact _____ **Phone** _____

Physician's Name _____ **Phone** _____

Preferred Medical Facility _____ **Phone** _____

Health Insurance Co. _____ **Phone** _____

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

_____

_____

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 "life saving" 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 Rider _____

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 Rider _____

RELEASE AND HOLD HARMLESS AGREEMENT

The program at the **Crossing Bridges Therapeutic Riding Center** 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 Therapeutic Riding Center,** 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 Therapeutic Riding Center**, 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 Therapeutic Riding Center**, 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 Therapeutic Riding Center,** 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 Therapeutic Riding Center,** 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.

Date _____

Participants Name (Print) _____

Participant or Parent/Guardian Signature _____

Print Parent/Guardian Name (If Applicable) _____

Relationship to Participant _____

Address _____

City _____ **State** _____ **Zip** _____

P H O T O R E L E A S E

Print Participant Name _____

Print Parent/Guardian/Caregiver Name (If Applicable) _____

Address _____

City _____ **State** _____ **Zip** _____

Photo Release > >

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to the **Crossing Bridges Therapeutic Riding Center** permission to take or have taken still and moving photographs and films, including television pictures, of my/our self-daughter-son-ward _____ *[participants name]* and consents and authorizes the **Crossing Bridges Therapeutic Riding Center** 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 Therapeutic Riding Center** and its work.

_____ _____

Participant or Parent/Guardian Signature **Date**

Relationship to Participant _____

POSSIBLE REASONS FOR TERMINATION OF SERVICES

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. 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 Therapeutic Riding Center entirely.

> > Patient/client has reached all their goals!

> > Patient's/client'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 patients/ clients and/or staff.

> > Patient/client exceeds weight that can safely be managed by staff, volunteers, and/or therapy horses.

> > Any change in the patient's/client'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 treating therapist and/or instructor.

> > Non-payment of billed funds after 90 days.

_____ _____

Signature of Patient/Client or Legal Guardian/Caregiver **Date**

CANCELLATION POLICY

Your appointment is very important to the Crossing Bridges 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 of Patient/Client or Legal Guardian/Caregiver **Date**