Mailing Address:
35954 Cypress Lane
Prairie du Chien, WI 53821
Phone: 608-412-2692
Email: allied.h.inc@gmail.com

Client Registration Form

*Required

*Client Name: ____

*Phone__________________________ Email_______________________________________

*Street__________________________*City______________________________*Zip_______

*Date of Birth ___________________ *Age ______ *Height ____________ *Weight_____________

Parent/Guardian ____________________________________ Relationship ____________________

Phone __________________________ Email_______________________________________

Second Phone _____________________ Email ______________________________________

*What phone number is best used in the event of lesson cancellations? ________________________

What email is best used in the event of lesson cancellation? _________________________________

In case of an emergency, is there someone we should call? ☐Yes ☐No

Name & Relationship ________________________________ Phone _______________________

Is there any emergency information or procedures you would like us to follow in case of emergency?

____

____

How did you hear about the program? ____

Have you participated in Equine-Assisted therapeutic programs before? _______________________

If yes, when, where, and for how long? ____

Are you or anyone in your family a Veteran or active in the military?_____________________________

Please indicate which session(s) and program(s) you are interested in registering for:

☐Session I (May-July)

☐Session II (Aug.-Oct.)

☐New Client Assessment

☐Therapeutic Riding

☐Unmounted Activities

☐Veterans Program

Please indicate your choices of days & times available (flexibility is appreciated)

____

____

____

FOR OFFICE USE ONLY: (Date & Initial)

# of Vols: Min_______ Pref ______ Other __________________________

New and Returning Clients

GOALS (What would you like to gain from this session experience?)

____

____

____

New Clients Only

Describe your abilities/difficulties in the following areas (including assistance required or equipment needed):

PHYSICAL (Mobility skills such as transfers, walking, wheelchair use, etc.)

____

____

____

PSYCHOLOGICAL/SOCIAL (work/school, leisure interests, companion animals, fears/concerns)

____

____

____

OTHER INFORMATION YOU WOULD LIKE TO SHARE

____

____

Allied Horsemanship, Inc. Program Policies:

- Fees: Equine Assisted Activities and Unmounted Activities $25 per group lesson, $30 per private lesson
- Payment will be refunded if client is unable to participate in appropriate class and activity, and/or Allied Horsemanship, Inc. is notified of conflict prior to the start of the session. A credit, minus any processing fees, will be applied to the account for withdrawal after the start of the session. <u>NO REFUNDS OR MAKEUPS will be offered for vacations, temporary illness, or unanticipated circumstances</u>. Refunds will be given if a client withdraws for the entire session due to medical necessity *with written notification from client's medical provider*.
- Rider/family/guardian is directly responsible for amounts not authorized or paid for by third party billing sources.
- Credit will be applied to client's account when Allied Horsemanship, Inc. initiates cancellation of lesson or session. Credit must be used by end of following calendar year, meaning credits carried from 2017 must be used by end of 2018. Credits may be donated to Allied Horsemanship Sponsorship Fund.
- Clients with inappropriate shoes (including crocs, sandals, open-toes or open-heeled) and clothing, or clients arriving more than 10 minutes late for activities, will not be able to join their class. Fees will not be refunded.
- **NO DOGS** allowed on Allied Horsemanship, Inc. grounds. Service dogs have to be approved by the director due to safety with horses.

I have read, understand and agree to Allied Horsemanship's lesson policies.

Signed:____ Date: ___________________

Client (over age 18), Parent or Guardian

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Email: allied.h.inc@gmil.com

Client Medical History/Physician's Statement

Dear Healthcare Provider,

Your patient, ____, is interested in participating in supervised equine activities. In order to safely provide this service, our center requires that you complete the attached Medical History/Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Atlanto-axial Instability – includes neurologic symptoms
Coxarthosis
Cranial Defects
Heterotopic Ossification/Myositis Ossifications
Joint subluxation/Dislocation
Osteoporosis/Osteoarthritis
Pathologic Fractures (history of)
Spinal Joint Fusion/Fixation
Spinal Joint Instabilities/Abnormalities
Degenerative Joint Disease
Myopathy

Neurologic

Hydrocephalus/Shunt
Seizures
Spina Bifida/Chiari II Malformation/
Tethered Cord/Hydromyelia/Syringomyelia
Neuropathy

Other

Age – under 4 years
Indwelling Catheters/Medical Equipment
Medication reactions – i.e. Photosensitivity
Poor Physical Endurance
Skin Breakdown/Condition

Medical/Psychological History

Allergies
Animal Abuse
Cardiac Condition/Heart Disease
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangers to self or others, history of
Exacerbations of Autoimmune Conditions (i.e. M.S., RA)
Fire Setting/Arsis
Hemophilia/Taking Blood Thinners
Migraines/Chronic Headaches
Peripheral Vascular Disease
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders
PTSD
Depression
Anxiety

Thank you so much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact our center.

Sincerely,
Allied Horsemanship, Inc.

Participant: ______________________________ DOB: ________________ Height: _________ Weight: ________________
Address: _____________________________________ City: ______________________________ State: _____ Zip: ______
Diagnosis: ____ Date of Onset: ____________________
Past/Prospective Surgeries: ____
Medications: ____ For: ___________________________
Seizure Type: ____ Controlled Y N Date of Last Seizure: ______
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices: ____________________________ Shunt Present: Y N Date of Last Revision: ________
For those with Down Syndrome: Neurologic Symptoms of Atlantoaxial Instability: ☐Present ☐Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

- Auditory No Yes ____
- Visual No Yes ____
- Tactile Sensation No Yes ____
- Speech No Yes ____
- Cardiac No Yes ____
- Circulatory No Yes ____
- Integumentary/Skin No Yes ____
- Immunity No Yes ____
- Pulmonary No Yes ____
- Neurologic No Yes ____
- Muscular No Yes ____
- Balance No Yes ____
- Orthopedic No Yes ____
- Allergies No Yes ____
- Learning Disability No Yes ____
- Cognitive No Yes ____
- Emotional/Psychological No Yes ____
- Pain No Yes ____
- Other No Yes ____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. 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.

Medical Professional:

Name/Title: ____ MD DO NP PA Other ________

Signature: ____ Date: ___________________

Address: ______________________________________ City: ____________________________ State: _____ Zip: _______

Phone :(______) _______________________________ License/UPIN Number: _______________________

Participant, Parent, or Legal Guardian: To the best of my knowledge the medical history is true and accurate.

Signature: ____ Date: _______________

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Client Release Form

Client: ______________________________________ Email: ____
Home Phone: ___________________________________ Work/Cell Phone: _____________________________
Address: ____
City: ____ State: _________ Zip: ___________
Parent/Guardian(s): ____
Address (if different from client): ____
Phone: ______________________________ Email: ____

Liability Release (REQUIRED)
In return for being allowed to use the Allied Horsemanship, Inc. Equine Assisted Activities Program, including its facilities, horses, and equipment, where applicable for horseback riding and other horse related activities, I/my son/my daughter/my ward__________________________(Client's Name) agree to abide by all of the rules and regulations of Allied Horsemanship, Inc. now in effect or later adopted. In addition, I hereby agree to assume all responsibility and risk from my/my son/my daughter/my ward's participation in activities of Allied Horsemanship, Inc. I further agree to hold Allied Horsemanship, Inc., its Board of Directors, Instructors, Aids, Volunteers, and/or Employees free and harmless from all damages or liability for any injury to person or property arising as a result of the use of facilities, horses, and/or equipment owned or leased to Allied Horsemanship, Inc., including any injury caused by their negligence.

I am aware of the significant risk of injury that horseback riding and horse-related activities may cause to myself/my son/my daughter/my ward; however, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than and outweigh the risk assumed. By signing this agreement I am assuming all risk and do hereby understand that horses are animals, not subject to any guarantee of reliability. Therefore, I agree to release, indemnify, and hold harmless Allied Horsemanship, Inc., the Board of Directors, Instructors, Aids, Volunteers, and/or Employees from all liability they may incur.

In accordance with the Wisconsin Law relating to the limitation of civil liability regarding equine activities: "NOTICE: A person who is engaged for compensation in the rental of equines or equine equipment or tack or in the instruction of a person in the riding or diving of an equine or in being a passenger upon an equine is not liable for the injury or death of a person involved in the equine activities resulting from the inherent risks of equines activities, as defined in section 895.481 (1) (e) of the Wisconsin Statues."

Signature____ Date ___________________________
Client (over age 18), Parent or Guardian

Print Name ____ Phone __________________________

Photo Release (REQUIRED)

☐I do ☐I do not consent to and authorize the use and reproduction by Allied Horsemanship, Inc. of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional materials, educational activities, and exhibitions or for any other use for the benefit of the program.

Exceptions: ____

Print Name ____ Phone ____________________________

Signature____ Date ______________________________

Client (over age 18), Parent or Guardian

Please sign one of the Consent Plans below

Consent Plan

In the event of an 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 Allied Horsemanship, Inc. to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individuals or agency involved in the medical emergency treatment.

This authorization includes x-rays, surgery, hospitalization, medication, and any treatment procedure deemed "life-saving" by the physician.
This provision will only be invoked if the person(s) above is unable to be reached.

Consent Signature: ____ Date: _____________________

Client (over age 18), Parent or Guardian

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 service on the property of Allied Horsemanship, Inc.
Parent or legal guardian will remain on site at all times during equine assisted activities. In the event that emergency treatment/aid is required, I wish the following procedures to take place: _______________________________________

____

Non-Consent Signature: ____ Date: ____________________

Client (over age 18), Parent or Guardian