

**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:

Adaptive 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:**

- 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. NO REFUNDS OR MAKEUPS will be offered for vacations, temporary illness, or unanticipated circumstances. 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. 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*



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



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

## 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 driving 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 Statutes."

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*