GUARDIAN THERAPEUTIC HORSEMANSHIP

896 North Vicha Road Axtell, TX 76624
Ph: 254-717-1779

2024 REGISTRATION

Participant:_____DOB:_____ Age:_____

Address:_____City:_____Zip:_____

Primary Phone:_____Secondary Phone:_____

_____

FOR MINORS OR ADULTS WITH LEGAL GUARDIANS

Parent or Guardian:_____Occupation:_____

Employer:_____Work Phone:_____Cell:_____

Address if different than participant:_____

Relationship to participant:_____

Please name any caregivers/ phone numbers who may transport or be responsible for Participant:

_____

_____

IN CASE OF EMERGENCY

In the event of a medical emergency, Guardian will provide basic first aid and/or call 911 and will disclose all available health care information to emergency personnel.

Please list **TWO** emergency contact names and phones:

Name:_____Phone:_____

ALLERGIES:_____

MEDICATIONS:_____

_

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Release waiver of liability

Student_____
Volunteer_____

I choose to participate in equestrian activities with Guardian Therapeutic Horsemanship Inc. and in order to do so I agree to the following waiver of liability.

I understand that in this agreement the term horseback riding means riding, handling, grooming and general care of horses. The term horses means all equine species, and the term rider means a person who mounts a horse or handles, grooms or comes near a horse while on the ground.

I understand that horseback riding is an inherently dangerous activity and there are numerous risks that may or may not be apparent in horseback riding regardless of safety precautions. I understand that horseback riding, whether in an enclosed riding arena, on a trail or in a pasture, and whether mounted, while working with a horse on the ground, or while grooming, bathing, and tacking, involves a calculated risk to riders. I further understand that riding in an unenclosed arena constitutes an additional risk.

I understand that although Guardian chooses its school horses for their calm dispositions and sound basic training, no horse is completely safe. If a horse is

frightened or provoked it may forget its training and act according to its natural survival instinct without warning or any apparent cause. I understand that among other things, a horse may buck, rear, stop suddenly, change direction or speed at will and unpredictably, shift a way in a manner that throws a rider off balance, bite, kick, spook, step on, push or shove a rider. Further, horses may trip, stumble or fall. I understand that any of these may cause a rider to fall, be thrown, jolted, injured or killed and I understand the unpredictability of horses and agree to assume all risk inherent in horseback riding.

I understand and agree that I accept full responsibility for bodily injury, property damage, death, medical and other financial loss expenses to include, but not limited to, time lost from school or work or disability, which are sustained by any member of my group on or in relationship to the premises and operations of Guardian Therapeutic Horsemanship and or while riding or handling horses and that I hereby for myself, my heirs, do hereby release and discharge Guardian Therapeutic Horsemanship from all claims.

I agree that riders must abide by and follow all instructions given and rules established by Guardian Therapeutic Horsemanship regarding riders' use of the horses, equipment and gear provided by Guardian Therapeutic Horsemanship.

I RELEASE, DISCHARGE AND PROMISE NOT TO SUE Michelle Patterson, founder and operator of Guardian Therapeutic Horsemanship, from and in regard to all laws, liability, damage or cost arising out of or related to any loss, damage, injury or death to rider's person or property arising from or related to horseback riding.

I understand that this agreement is governed by the law of the state of Texas.

By signing this agreement you are giving up on your behalf and on behalf of the other bound parties certain legal rights, including the right to recover damages in the event of injury, death or property damage. Please read this entire agreement carefully before signing.

WARNING: Under Texas law Chapter 87, civil practice and remedies code, a farm animal professional is not liable for injury to or the death of a participant in equine activities that result from the inherent risk of farm animal activities.

“ I, the undersigned, have read and do understand the foregoing riding and horsemanship instruction agreement and liability release waiver.

Signature:_____
(must be 18 years of age or older, legally responsible, or parent/guardian must sign)

Print name as shown above:_____

Participant’s name (if applicable):_____

Date:_____

Address:_____

City:_____. State:_____. Zip:_____

Home phone:_____. Work phone:_____

Cell phone:_____

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HEALTH HISTORY

Participant's name:_____DOB:_____

Height:_____Weight:_____Grade:_____Age:_____

List **ALL** diagnoses or disabilities:_____

_____

If the answer to any of the following health questions is yes, a physicians release form is required.

Down syndrome:_____. Spinal condition/injury:_____ Diabetes:_____

Cerebral palsy:_____. Stroke:_____ bleeding/clotting disorder:_____

_

Joint conditions:_____. Epilepsy:_____. Heart condition:_____

Details of above condition please:_____

_____

MEDICATIONS

_____

_____

Does participant have:

Asthma:_____. Epipen:_____ inhaler:_____

Allergies:_____

I hereby affirm that, to. The best of my knowledge, the health history information is complete and correct.
Name of person completing this form:_____Date:_____

Signature:_____ Relationship to participant:_____

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PHOTO RELEASE FORM

The undersigned hereby grants Guardian Therapeutic Horsemanship permission to take photographs and/or videos of myself and/or the participant for use by Guardian Therapeutic Horsemanship to help promote the business.

I consent:_____ I do not consent:_____

Signature:_____ Date:_____

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Authorization for emergency medical treatment

Student:_____Volunteer:_____

Name:_____Date of Birth:_____

Address:_____Phone:_____

Preferred medical facility:_____Physicians name:_____

Health insurance provider: _____ID#_____

Group#:_____

EMERGENCY CONTACT

Name:_____Relation :_____Phone:_____

Name:_____Relation:_____Phone:_____

Allergies to medications:_____

Current medications:_____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, volunteering, or while being on the property of the agency, I hereby authorize Guardian Therapeutic Horsemanship to:

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

CONSENT PLAN (parents/legal guardian for children under 18)
This authorization includes x-ray, surgery, hospitalization, medication, and any treatment deemed by the physician. This provision will only be invoked if the person below is unable to be reached.

Date:_____ consent signature:_____Print name:_____

Phone:_____Address:_____

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. In the event emergency aid/treatment is required, I wish the following procedures to take place:

_____

_____

Date:_____ consent signature:_____ printed name:_____

Phone:_____ address:_____

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PARTICIPANTS MEDICAL HISTORY AND PHYSICIANS STATEMENT
(To be completed by primary physician)

This form must be completed before you will be able to ride!

Participants Name:_____Date of Birth:_____

Address:_____phone:_____

Height:_____Weight:_____Name of parent/guardian:_____

Diagnosis:_____

*for persons with Down Syndrome: 1. Negative cervical x ray for Atlantoaxial Instability X-ray date:_____

2. Negative for clinical symptoms of Atlantoaxial Instability:_____

Seizure Type:_____Controlled:_____Date of last seizure:_____

Medications:_____

Precautions for outdoor activities?(allergies,sun/heat sensitivity, asthma, etc):_____

Please indicate if patient has issue and/or surgery with yes or no. If yes please comment

Auditory:_____visual:_____

Speech:_____Cardiac:_____

Circulatory:_____Pulmonary:_____

Neurological:_____Muscular:_____

Orthopedic:_____Allgeries:_____

Learning Disabilities:_____Mental Impairment:_____

Other:_____

PHYSICIAN STATEMENT

To my knowledge there is no reason why _____ cannot participate in supervised equestrian activities

Physician Name:print_____

Signature:_____Date:_____

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SEIZURE EVALUATION FORM

If participant has experienced seizure activity with in the past 12 months the following form is required. Please complete this form including as much information as possible. Since riding and working around horses is a risk activity conditions that increase that risk are carefully analyzed

Student's Name:_____DOB:_____Age:_____

Parent/Guardian Name:_____Phone:_____

Type of seizure(list all types):_____

_____

Is your child under the care of a physician? Yes. No

Date of last seizure:_____**Duration of average seizure:**_____

Typical causes of seizure:_____

_____

Seizure activity indicators:_____

_____

During a seizure I/my Child(please explain what May occur during a seizure): _____

_____

_____

After affect:_____

_____

Should you or your child experience a seizure while at Guardian, Beyond employing general first aid and seizure protection methods what actions do you request we take?

_____

_____

_____

Call 911:_____

Report observations to parent/guardian immediately:_____

Please list below any further information that you would like to share:_____

_____

_____

_____

_____

Student/parent/guardian signature:_____Date:_____

GTH instructor:_____Date_____