



**Ride To Fly**

Mailing Address: PO Box 4991, Palos Verdes, CA 90274

Barn Location: 50 Narcissa Dr., Rancho Palos Verdes, CA 90275

Barn Telephone: (310) 541-4201

**CLIENT REGISTRATION AND RELEASE FORM**

**Registration**

Client: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

*(Street, City, State, Zip Code)*

Phones: Work (\_\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

Email address: \_\_\_\_\_

School/Institution presently attending: \_\_\_\_\_

Name & Phone of OT, PT and/or SLP: \_\_\_\_\_

Name & Phone of OT, PT and/or SLP: \_\_\_\_\_

Parents/Guardians: \_\_\_\_\_

Address*(If different from client)*: \_\_\_\_\_

Phones: Work (\_\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

In case of emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Or contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**1<sup>st</sup> & 2<sup>nd</sup> choice of Lesson Day Winter:** Tue (1-4PM) \_\_\_ Wed (1-4PM) \_\_\_ Thu (1-4PM) \_\_\_ Sat (9:30-12PM) \_\_\_

**1<sup>st</sup> & 2<sup>nd</sup> choice of Lesson Day Summer:** Tue (9-12PM) \_\_\_ Wed (9-12PM) \_\_\_ Thu (9-12PM) \_\_\_ Sat (9:30-12PM) \_\_\_

**LIABILITY RELEASE**

\_\_\_\_\_ (Client's Name) would like to participate in the Ride To Fly (Operating Center's Name) program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/my child/ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Ride To Fly, its Board of Directors, Instructors, Therapists, Employees, Aides and/or Volunteers for any and all injured and/or losses that I/ my child/ward may sustain while participating in Ride To Fly.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Client/Parent/Guardian

**PHOTO RELEASE (Optional)**

I hereby consent to and authorize the use and reproduction by Ride To Fly (Operating Center's Name) of any and all photographs and any other audiovisual materials taken of me/my child/ward for promotional printed material, educational activities, or for any other use for the benefit of the program.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_



## **Ride To Fly THERAPEUTIC HORSEBACK RIDING PROGRAM CLIENT RELEASE AGREEMENT**

I understand that there are risks and dangers inherent in participating and/or receiving instruction in the Ride To Fly therapeutic horseback riding or related activities, and/or in caring for, feeding, transporting, or riding horses and/or ponies, and in being in close proximity to such animals. I also understand that in order to be allowed to participate and/or receive instruction in the Ride To Fly therapeutic horseback riding or related activities, and/or in caring for, feeding, transporting, or riding horses and/or ponies, and in being in close proximity to such animals, I must give up my rights to hold the Ride To Fly organization or any associated stable, facility, or organization liable for any injury or damage which I may suffer while participating and/or receiving instruction in the Ride To Fly therapeutic horseback riding or related activities, and/or in caring for, feeding, transporting, or riding horses and/or ponies, and in being in close proximity to such animals.

Knowing this, and in consideration of being permitted to participate and/or receive instruction in the Ride To Fly therapeutic horseback riding or related activities, and/or in caring for, feeding, transporting, or riding horses and/or ponies, and in being in close proximity to such animals, I hereby voluntarily release the Ride To Fly organization and any associated stable, facility, or organization from any and all liability resulting from or arising out of my participation and/or receipt of instruction in the Ride To Fly therapeutic horseback riding or related activities, and/or in caring for, feeding, transporting, or riding horses and/or ponies, and in being in close proximity to such animals.

I understand and agree that I am releasing not only the entities set forth in the paragraph above, but also the officers, agents, and employees of those entities.

I understand and agree that this Release will have the effect of releasing, discharging, waiving, and forever relinquishing any and all actions or causes of action, including action for negligence, that I may have or have had, whether past, present or future, whether known or unknown, and whether anticipated or unanticipated by me, arising out of my participation and/or receipt of instruction in the Ride To Fly therapeutic horseback riding or related activities, and/or in caring for, feeding, transporting, or riding horses and/or ponies, and in being in close proximity to such animals. This Agreement constitutes a complete release, discharge, and waiver of any and all actions of causes of action against Ride To Fly, and its officers, agents, employees, and against any associated stable, facility, or organization, and their officers, agents, and employees.

I understand and agree that this Release applies to personal injury, property damage, or wrongful death which I may suffer, even if caused by the act or omissions of others.

I understand and agree that by signing this Release, I am assuming full responsibility for any and all risk of death or personal injury or property damage suffered by me while participating and/or receiving instruction in the Ride To Fly therapeutic horseback riding or related activities, and/or in caring for, feeding, transporting, or riding horses and/or ponies, and in being in close proximity to such animals.

I understand and agree that this Release will be binding on me, my spouse, my heirs, my personal representatives, my assigns, my children, and any guardian ad litem for said children.

I understand that if I were to file a lawsuit against any of the above named entities, or any of their officers, agents, or employees as a result of any personal injury or property damage suffered by me while participating and/or receiving instruction in the Ride To Fly therapeutic horseback riding or related activities, and/or in caring for, feeding, transporting, or riding horses and/or ponies, and in being in close proximity to such animals, that this Release would operate to bar that lawsuit and that the lawsuit would be dismissed by the court on the grounds that I have expressly assumed the risks associated with participation and/or receipt of instruction in the Ride To Fly therapeutic horseback riding or related activities, and/or in caring for, feeding, transporting, or riding horses and/or ponies, and in being in close proximity to such animals.

I understand and agree that by signing this Release, I am agreeing to release, indemnify and hold Ride To Fly and its officers, agents, and employees harmless from any and all liability or costs, including attorneys' fees, associated with or arising from my participation and/or receipt of instruction in the Ride To Fly therapeutic horseback riding or related activities, and/or in caring for, feeding, transporting, or riding horses and/or ponies, and in being in close proximity to such animals.



## Ride To Fly

I understand and agree that if I am signing this Release on behalf of my minor child/ward, that I will be giving up the same rights for said minor as I would be giving up if I had signed this Release on my own behalf.

I acknowledge that I have read this Release Agreement and that I understand the words and language in it. I have been advised of the potential dangers incidental to participating and/or receiving instruction in the Ride To Fly therapeutic horseback riding or related activities, and/or in caring for, feeding, transporting, or riding horses and/or ponies, and in being in close proximity to such animals. Large animals can cause injury, death, or damage due to their size and temperament.

I acknowledge that I am aware of and assume all risks noted above and that I wish to participate in the Ride To Fly therapeutic horseback riding or related activities, and/or in caring for, feeding, transporting, or riding horses and/or ponies, and in being in close proximity to such animals. To the extent that I participate in such activities, I do so voluntarily and I assume full responsibility for any loss and/or inconvenience resulting from an injury to myself, my minor child/ward, and or my property resulting therefrom.

Date \_\_\_\_\_

### **PARENT/GUARDIAN RELEASE**

I am the parent/legal guardian of the minor, \_\_\_\_\_, and am signing this Release on behalf of said minor.

Print Name of Parent/Guardian \_\_\_\_\_

*Signature of Parent/Guardian* \_\_\_\_\_

Witness: \_\_\_\_\_

### **CLIENT RELEASE (if applicable)**

Print Name of Client \_\_\_\_\_

*Signature of Client* \_\_\_\_\_

Witness: \_\_\_\_\_



# CLIENT EMERGENCY MEDICAL FORM

Client: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Parents/Guardians: \_\_\_\_\_

Address: \_\_\_\_\_

Phones: Work (\_\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

Client's Medical Diagnosis: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician Phone/Pager: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Medical Insurance Provider: \_\_\_\_\_

Medical Insurance Policy Number: \_\_\_\_\_

Name of one person authorized to give temporary assistance/care in event the listed parent/guardian cannot be contacted:

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Phones: Work (\_\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

Describe any medical condition requiring special precautions or treatment (such as allergies) and any medications and dosage that the client is currently taking (Write none if this is not relevant):

In case of medical emergency, the undersigned authorizes Ride To Fly personnel to provide such medical assistance as they determine to be necessary. Additionally, the undersigned authorizes any licensed physician and/or medical facility to provide any medical/surgical care and/or hospitalization for he rider, including anesthetic, which they determine necessary or advisable, pending receipt of a special consent form from the undersigned.

No person can be accepted for riding instruction until this form is completed by the parents/guardians. If the client is of legal age (18), he/she may complete the form if he/she is legally competent to do so. Riding instruction will be under strict supervision, and although every effort will be made to avoid any accidents, NO LIABILITY will be accepted by any of the organizations concerned, including Ride To Fly and the Palos Verdes Stables and their personnel, including volunteers (as indicated in the signed Therapeutic Horseback Riding Program Release Agreement).

I would like \_\_\_\_\_ (client) to have riding instruction, and I have discussed this with the client's doctor. I understand that NO liability can be accepted by any of the organizations concerned, including Ride To Fly and the Palos Verdes Stables and their personnel, including volunteers, in the event of any accident which may occur.

Signature of Parent/Guardian \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

Signature of Client(if applicable) \_\_\_\_\_



# Ride To Fly

## CLIENT MEDICAL HISTORY & PHYSICIAN RELEASE

Client: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Parents/Guardians: \_\_\_\_\_

Address: \_\_\_\_\_

Phones: Work (\_\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

**To be completed by the client's physician**

Client's Medical Diagnosis: \_\_\_\_\_

Date of onset: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Tetanus Shot: No \_\_\_ Yes \_\_\_ Date \_\_\_\_\_

Seizure Type: \_\_\_\_\_ Controlled? \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

Down Syndrome--Cervical x-ray for Atlantoaxial Instability: Positive \_\_\_ Negative \_\_\_ X-ray Date \_\_\_\_\_

Scoliosis: No \_\_\_ Yes \_\_\_ If yes, Degree of Curvature: \_\_\_\_\_

Mobility--Independent Ambulation: No \_\_\_ Yes \_\_\_

Mobility--Crutches: No \_\_\_ Yes \_\_\_ Braces: No \_\_\_ Yes \_\_\_ Wheelchair: No \_\_\_ Yes \_\_\_

Medications: \_\_\_\_\_

*Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment and use the back of this form if necessary.*

Areas	No	Yes	Comments (if Yes)
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

*Describe any other special precautions that we may need to know about:*

In my professional opinion, this person can participate in supervised equestrian activities. In conjunction with these activities, I concur in the referral of this person to a physical/occupational therapist or other health care professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program.

Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Physician Name: \_\_\_\_\_