VICTORY HILL THERAPEUTIC HORSEMANSHIP
1138 Mountain Rd., Port Jervis, NY 12771
845-843-0020 sara@victoryhillth.org
(Web) victoryhillth.org (Facebook) "Victory Hill TH"

Summer Horsemanship Program Registration Forms

Date: _____

I. CONTACT INFORMATION:

Name: _____
Mailing Address: _____City _____ ST_____ ZIP _____
Agency: _____
DOB: _____ Age: _____ Height: _____ Weight: _____

PATH Int'l sets weight limits for horse's safety. Ht. / Wt. is required to determine appropriate horse for rider

Phone: (Home) _____ (Cell) _____
Name: _____
Address: _____
Primary Phone: _____ Alternate Phone: _____
(Work) _____ E-mail address: _____

Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

All forms must be signed by parent/ legal guardian

I. Safety Guidelines

- No smoking ANYWHERE on the premises.
- Please refrain from loud noises, using umbrellas, running, or throwing objects while horses are being worked with, as this may distract horses and create an unsafe situation.
- For your safety, please refrain from climbing/ sitting on fences or gates.
- To ensure the longevity of our horses, mounted activities have weight limits.

II. Attire

- Dress appropriately for outdoor weather conditions and barn work.
- No open toed shoes or sandals. Please wear boots *(no steel toe)* or sneakers.
- Please wear long pants (for riding) and t-shirts *(no tank tops or inappropriate logos).*
- Tuck jewelry into clothing to prevent being snagged on equipment.
- ASTM-SEI *(American Society for Testing and Materials – Safety Equipment Institute)* helmets *(available at VHTH)* are required for mounted activities. You may also bring your own.

Authorization for Emergency Medical Treatment

Therapeutic Horsemanship

PREMIER ACCREDITED CENTER
PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

AUTHORIZATION:

Name: _____ DOB: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

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, or while being on the property of VHTH, I authorize Victory Hill TH to:

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

CONSENT PLAN

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

Consent Signature: _____ Date:_____
(*Volunteer/Staff/Parent/Legal Guardian/Authorized Caregiver*)

NON-CONSENT PLAN

Parent/Legal Guardian/Authorized Caregiver must remain on site at all times during equine assisted activities.

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 Victory Hill Therapeutic Horsemanship.

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

Non-Consent Signature: _____ Date:_____
(*Volunteer/Staff/Parent/Legal Guardian/Authorized Caregiver*)

Liability and General Release Form

RELEASES:

There are 3 separate releases on this form. Please sign and date for each release separately.

1. *LIABILITY RELEASE:*

I would like to participate in Victory Hill TH's program. I acknowledge the risks and potential for risks of horseback riding or working with or around horses. However, I feel that the possible benefits to me/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legal bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Victory Hill TH, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Staff or the property owners for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in any Victory Hill TH's programs.

Signature: _____ *Date:* _____

2. *HORSEBACK RIDING SAFETY PROTOCOLS:*

I understand that Victory Hill TH has weight limits for riding activities and riding may or may not be offered to me. I acknowledge that all riding activities require an ASTM-SEI *(American Society for Testing and Materials – Safety Equipment Institute)* helmet to be worn while riding and safety stirrups will be used on all English saddles used in therapeutic riding classes.

I have disclosed any and all health history that may be relevant to working with or around large animals and can attest that there is no medical reason that would have an adverse effect on my health by participating in these activities.

Signature: _____ *Date:* _____

3. *MEDIA RELEASE:* *for all promotional materials including (but not limited to) photographs, audio/videos, testimonials for our use on our website or Facebook page and/or for print*:

I, _____ (*print name*), ☐ **DO** ☐ **DO NOT** *(check one)* consent to and authorize the use and reproduction by Victory Hill TH of any and all audio/visual materials taken of me/my son/my daughter/my ward for promotional material, education activities, website, or for any other use for the benefit of the program.

Signature: _____ *Date:* _____ _____

Victory Hill
Therapeutic Horsemanship

Participant's Medical Clearance and Physician Statement

To be completed and *signed* by a Physician

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International
—MEMBER—

Participant: _____ DOB: _____

Address: _____City: _____ State: _____ Zip: _____

Diagnosis: _____ Date of Onset: _____

Height: _____ Weight: _____

PATH Intl. sets weight limits for horse's safety. Ht. / Wt. is required to determine appropriate horse for rider

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: **Y** **N** Date of last Seizure: _____

Shunt Present: **Y** **N** Date of last revision: _____

Special precautions/needs: _____

Mobility- Independent Ambulation: **Y** **N** Assisted Ambulation: **Y** **N** Wheelchair: **Y** **N**

Braces/Assistive Devices: _____

Neurological Symptoms of Atlantoaxial Instability: _____ Present _____ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	COMMENTS
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that Victory Hill TH will weigh the medical information above against the existing precautions and contraindications set by PATH Intl as defined by their safety standards.

Physician Name: _____ MD DO NP PA Other _____

Signature: _____ **Date:** _____

Address: _____

Phone: _____ License/UPIN Number: _____