Exceptional Equestrians Unlimited, Inc.
A Therapeutic Horseback Riding Program for those with Special Needs
P.O Box 53 - Hobart, IN 46342 219-945-0726
http://eeunwi.org
www.facebook.com/eeunwi
EEU is a PATH Intl. Accredited Program

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International
—MEMBER—

2017 Student Registration Form

Rider Name: _____ Date of Birth: ____/____/____ Age:_____
Height: _____ Weight:_____ Male / Female Favorite Color: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Favorite Color: _____ Years of Participation: _____
Parent or Guardian Name: _____
Street Address: _____ City: _____ State: _____
(If different from above)
Zip Code: _____ Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-Mail Address: _____

In Case of Emergency Contact: _____ Phone: _____

Disability: _____ Onset: _____

Mobility:_____Ambulatory _____ Personal Aids _____ Wheelchair
How did you hear about our program: _____
What medications are you currently taking, include over the counter medications? _____
_____
Does the participant have: Asthma: Y / N EpiPen: Y / N Inhaler: Y / N

PHOTO RELEASE (check one)

I_____DO **I_____DO NOT**

Hereby consent to, and authorize the use and reproduction by EEU (Exceptional Equestrians Unlimited, Inc.) of any and all photographs and any other audio/visual materials taken of my son/daughter/my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Signature:_____ Date:_____
Parent /Legal Guardian /Participant if over 18

I would like to register for: Spring session (8 weeks) April 3 - May 27 Mon / Tues / Thurs / Sat
Student recognition day is June 10

Fall Session (8 weeks) Sept. 11 - Nov. 4 Mon / Tues / Wed / Thurs / Sat
Student recognition day is November 11

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Participant Information/ Goal Sheet

Participant's Name: _____

Describe briefly what you think this participant's strengths and talents are:

Describe briefly what you think this participant's weaknesses are:

Check those that accurately describe the participant:

Best Teaching Strategy

_____ Auditory
_____ Visual
_____ Kinesthetic
_____ Visual-Kinesthetic
_____ Auditory-Visual
_____ Auditory-Visual-Kinesthetic

Laterality

_____Is able to differentiate between his/her left hand
_____Is able to differentiate between his/her right hand
_____Appears to use both right and left sides equally

Motor Coordination and Body Image

_____ Has tightly muscled body
_____ Has low muscle tone
_____ Has average muscle tone
_____ Is coordinated and plays in many sports well
_____ Has difficulty playing some sports
_____ Does not like to be touched
_____ Does not seem to be aware of his body in space
_____ Pays attention to body cues, knows when hungry, tired and takes care of bodily needs
_____ Is skin sensitive and complains at times that clothing is too rough or hurts
_____ Stumbles and trips, runs into things or knocks things over often

Social and Emotional Adjustment

_____ Appears to be appropriately independent, self-reliant, and mature for age
_____ Appears to have a positive self-image
_____ Can be very hard on him or herself
_____ Whines, complains and generally manipulates
_____ Is able to get along with others
_____ Is direct and can ask for what he/she needs and wants
_____ Performance is uneven and marked good and bad days
_____ Tires easily
_____ Is argumentative and oppositional at times
_____ Wants to please
_____ Has anxiety exhibited by stomach aches, headaches or other physical symptoms
_____ Shows anxiety by chewing on clothing, toys or own body

Observed Behaviors

_____ Distracted by internal stimuli
_____ Distracted by external stimuli
_____ Needs constant reminders to stay on task
_____ Needs occasional reminders to stay on task
_____ Is easily bored
_____ Needs several minutes to process information before acting
_____ Needs repetition in order to internalize feedback or instruction
_____ Once something is learned can remember to correct his/herself
_____ Gives up when frustrated
_____ Is determined and keeps trying

Please check the top 5 goals for your participant:

Physical	**Social & recreational**	**Cognitive**
____Improved balance	____Cooperation	____Color recognition
____Improved posture	____Sportsmanship	____Shape recognition
____General coordination	____Enjoyment	____Verbalization
____Eye/Hand coordination	____Confidence/ self-esteem	____Sequencing
____Head control	____Communication skills	
____Trunk control	____Attention (increase/decrease)	
____Strength	____Responsibility	
____Gross motor skills	____Social skill development	
____Fine motor skills	____Teamwork	
____Muscle tone	____Respect	
____Socialization	____Trust	
____Decrease tactile defensiveness		
____Increased range of motion		
____Visual/ spatial orientation		

Do you have any other comments or goals that would help us better understand the participant?

Signature: _____ Date: _____

Relationship to participant: _____

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Participant's Medical History and Physician's Statement

Participant:_____DOB:_____/_____/_____Height:_____Weight:_____
Address:_____City:_____State:_____Zip:_____
Diagnosis:_____Date of Onset:_____/_____/_____
Past/Prospective Surgeries:_____
Medications:_____
Seizure Type:_____Controlled: Yes No Date of Last Seizure:_/_____/_____
Shunt Present: Yes No Date of last revision: _____/_____/_____
Mobility: Independent Ambulation: Yes No Assisted Ambulation: Yes No Wheelchair: Yes No
For those with Down Syndrome: AtlantoDens Interval X-Rays Date:_/_____/_____ Result: Pos Neg
Neurologic Symptoms of Atlanto Azial Instability:_____
Please indicate difficulties, Medical conditions and/or surgeries in any of the following areas below by checking Yes or No.
If Yes, please comment.

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

This form MUST be signed and dated by a MD, DO, NP, PA, or other Medical Professional below.

Given the above diagnosis and medical information, this person is not medically preclude for participation in equine assisted activities and/or therapies including riding and /or carriage driving. I understand that EEU will weigh the medical information given against the existing precautions and contraindications.

PHYSICIAN'S SIGNATURE:_____Date:_____/_____/_____

Clearly Print Name & Title:_____License/UPIN#:_____

Address:_____

Phone: ()_____-_____ Please indicate: MD DO NP PA Other:_____

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Statistical Survey Confidential

Because our lesson fees cover only a small portion of the estimated operating cost for each rider, Exceptional Equestrians Unlimited, Inc. relies heavily on private donations as well as grant and foundation gifts. Many foundations fund programs according to specific guidelines and this statistical information affords us the ability to properly and appropriately apply for much needed funds. Your cooperation is much appreciated and all information is completely confidential.

For Statistical Use Only

Completion of this form will assist Exceptional Equestrians Unlimited, Inc. in tracking information needed to apply for grant funding for the program. The information is kept separate from your application is never used to determine Exceptional Equestrians Unlimited, Inc. program eligibility.

Rider's Name:_____

Sex ( ) Male ( ) Female Date of Birth: ____/____/____

Address: _____ City: _____State:_____Zip: _____

County: _____ Phone: (____) _____

Race:
( ) American Indian/Alaskan ( ) Hispanic
( ) Asian/Pacific Islander ( ) White (non-Hispanic)
( ) Black ( ) Other _____

Disability: _____

Annual Household Income (please check)

( ) $0-$10,000 ( ) $11,000-$20,000 ( ) $21,000-$30,000

( ) $31,000-$50,000 ( ) $50-$75,000 ( ) $75,000 +

Number in family: _____ Number of employed Family Members: _____

Parent/ Guardian Signature: _____ Date: ___/____/_____

For Office Use Only Date: ___/____/_____.

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Release and Assumption of Risk Agreement

I agree to the following Release and Assumption of Risk Agreement with Exceptional Equestrians Unlimited, Inc. (EEU) as a condition for allowing me and my child/legal ward identified below to enter EEU's premises, surrounding land and other program locations, be near horses, participate in equine-assisted activities, work near horses, handle horses, use equipment, work with staff and volunteers, and/or receive instruction or guidance while riding, driving, grooming, or handling horses. This is not meant to be a complete list of all activities and will be referred to in this document as "The Activities".

IT IS HERE BY AGREED AS FOLLOW

1. I have voluntarily requested, for myself or for my child/legal ward indentified below, to engage in any or all of The Activities, now and/or in the future.
2. **Risks:** Understand that anyone engaging in The Activities can suffer bodily injuries, property damage and other injuries including death. Participation in The Activities involves certain inherent risks and, regardless of the care that is taken, it is impossible to ensure the safety of the participant. *I understand the risks/dangers inherent in The Activities, and I agree to assume them, I am not relying on EEU to list all possible risks for me or my child/legal ward.*
3. **Waiver And Liability Release**: As consideration for EEU allowing me or my child/legal ward to engage in The Activities at anytime and at any location, I do hereby voluntarily assume all risks of loss, damage or personal bodily injury including death that may be sustained which may hereinafter occur on account of, or in anyway arising from, entry upon the premises or participation in The Activities on or off the premises. I, for my heirs, administrators, personal representatives, or assigns, release and discharge EEU and all EEU employees, assistants, directors, volunteers, instructors, officers, and owners of horses from and and all claims, demands, damages, actions, omissions, suits or causes of action (present or future).
4. **Indemnification:** I also understand and agree to indemnify and hold harmless EEU and persons or entities working on behalf of or affiliated with EEU against any and all further claims or damages, cost or expenses incurred by EEU and their employees as a result of an accident, injury or property loss which may occur while I, or my child/legal ward are on or off the premises or engaged in The Activities connected with EEU which may result from negligence of the undersigned or the negligence of EEU, employees, volunteers, instructors, agents, third parties or any combination thereof of EEU. The indemnification shall include reimbursement of EEU attorney fees.
5. **ASTM/SEI headgear:** EEU will provide me or my child/legal ward with an equestrian safety helmet that is ASTM standard and SEI-certified for use when riding or driving horses. I understand that neither EEU nor its assistants or agents can guarantee the suitability of any helmet provided.
6. **Health and Disabilities:** I understand that EEU always recommends that I seek the advice of a physician if I or my child/legal ward is injured, and many of The Activities pose special physical risks to the participant.
7. Should I breach this Release (or any part of it) I agree to pay the attorney's fees and court costs related to such breach incurred by EEU and/or persons directly affiliated with EEU. It is also mutually agreed that any disputes arising under this Release, or any Activities that are undertaken pursuant to this document, shall be litigated in a court of proper jurisdiction located in or nearest to EEU.

I understand that when signed, this Agreement is intended to be legal, valid and binding at all times, now and in the future, when EEU permits me or my child/legal ward to engage in any or all of The Activities either on the EEU premises or other designated program locations.

Warning: Under Indiana Law, an equine professional is not liable for an injury to, or the death of , a participant in equine activities resulting from the inherent risks of equine activities. Indiana Code 34-31-5

Name of Participant _____

Signature of Participant if 18 or older _____

Address of Participant _____

Phone (home)_____(cell)_____E-mail_____

I hereby certify that I am authorized to sign this Release and Assumption of Risk Agreement on behalf of the Participant.

Signature of Parent or Legal Guardian_____

Print name of Parent or Legal Guardian _____

Address _____

Phone (home)_____(cell)_____E-mail_____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

____Participant ____Volunteer _____Instructor

Name: _____ Date of Birth: ____/____/_____ Phone: (_____)_____

Address: _____ City: _____ ST: _____ Zip: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy#: _____

Allergies to Medication: _____

Current Medications: _____

Health History – Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Address fitness, cardiac, respiratory, bone or joint function and recent hospitalizations and/or surgeries.

_____

_____

In the event of an emergency contact:

Name: _____ Relation: _____ Phone: (_____)_____

Name: _____ Relation: _____ Phone: (_____)_____

Name: _____ Relation: _____ Phone: (_____)_____

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 the agency, I authorize Exceptional Equestrians Unlimited, Inc.:

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 "life-saving" by the physician. This provision will only be invoked if the above person(s) above is unable to be reached.

Date: ____/_____/_____ Consent Signature: _____
Client, Parent or Legal 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 services or while being on the property of the agency. Parent or Legal guardian will remain on site at all times during equine assisted activities. In the event emergency treatment aid is required, I wish the following procedure to take place.

_____

_____

Date: ____/_____/_____ Consent Signature: _____
Client, Parent or Legal Guardian