RIDER INTAKE FORM

THIS FORM MUST BE COMPLETED IN FULL AND SIGNED BEFORE A RIDER IS ALLOWED TO PARTICIPATE

Name: _____ Birth Date: _____ Age: _____

E-mail: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Place of Employment: _____

School/Educational Institution attending: _____

If under 18, please complete the following:

Legal Guardian/s: _____ Email: _____

Place of Employment: _____

Home/Cell Phone: _____ Work Phone: _____

In case of emergency, notify: _____

Relationship: _____ Contact number: _____

For Office Use Only

Date Application Received & Processed

RIDER INTAKE FORM

Client Name: _____

Medications (please include prescriptions and over the counter drugs)

Name of Drug	Dosage	Frequency	Side Effects
1.			
2.			
3.			
4.			
5.			

Allergies to any medication? If so, list them below:

_____
_____
_____
_____
_____

Past and Prospective Surgeries (please include date of surgery)

_____
_____
_____
_____
_____

Does this rider have any physical disabilities?
If yes, proceed with the next page
If no, proceed to page 4

_____
_____
_____
_____
_____

RIDER INTAKE FORM

Client Name: _____

Please describe abilities/difficulties in the following areas, including assistance required or equipment needed:_____
_____
_____
_____
___

Physical Function (ex: mobility skills such as transfers, walking, wheelchair use, etc.)

Please circle yes or no:

Rider is…

Ambulatory – Y / N

Verbal – Y / N

Uses a wheelchair – Y / N

Uses crutches – Y / N

Uses braces – Y / N

Uses a walker – Y / N

Can sit independently – Y / N

What are the goals for the rider? Why are you seeking participation, and what would you like to accomplish?

_____
_____
_____
_____
_____

Does this rider have any emotional/behavioral concerns?
If yes, proceed to the next page
If no, proceed to page 5

_____
_____
_____
_____
_____

RIDER INTAKE FORM

Client Name: _____

Any history of:

Issue	Yes	No
Depression		
Suicide Attempts		
Anxiety		
Eating Disorders		
Mental Illness		
Emotional Abuse		
Physical Abuse		
Sexual Abuse		
Addiction		
Chronic Illness		
Self Harm		
Violent Behavior		

Any history of alcohol or drug abuse? Y / N
If yes, please specify: _____

Any major stressors in the last 12 months?
(Ex: serious illness, death of a friend/family member, divorce, major illness in the family, etc.)

If yes, please specify: _____

Has the client ever been hospitalized for a psychiatric or emotional health reason?

If yes, please specify: _____

RIDER INTAKE FORM

Client Name: _____

Please list below who is allowed to pick up this rider from our facility.

If there is anyone who is legally not allowed to pick up this rider from our facility, please list them below and provide the court order.

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Client Name: _____

Are there any other concerns or information we should be aware of before beginning Therapeutic Riding sessions?

Honesty Declaration:
I, _____, attest that the answers provided throughout this volunteer information form have been answered truthfully and completely to the best of my recall. I attest that I have not deliberately or intentionally misrepresented my medical, social or psychological history in any way with my responses.

Print Full Name
_____ **Date:** _____

Rider/Parent/Guardian Signature

RIDER INTAKE FORM

Client Name: _____

EMERGENCY MEDICAL TREATMENT

Attending Physician: _____

Phone number: _____

Preferred Medical Facility: _____

Phone number: _____

Health Insurance Company: _____

Name of Policy Holder: _____

Policy #: _____

RIDER INTAKE FORM

Client Name: _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In case of medical emergency, the rider or guardian authorizes **KAP Equine Services Corp.** to secure and retain such emergency medical assistance and transportation as they determine to be necessary and proper. The rider or guardian authorizes release of rider records upon request to the authorized individual or agency involved in the medical emergency treatment. 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 guardian cannot be reached.

Rider/Parent/Guardian signature
_____ **Date:** _____

RIDER MEDICAL NON-CONSENT

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 **KAP Equine Services Corp.** In

the event emergency treatment is required, I wish the following procedures to take place:

Rider/Parent/Guardian Signature
_____ Date: _____

RIDER INTAKE FORM

Client Name: _____

Photo Release
I do____do not____ (check one) consent to and authorize the use of reproduction by **KAP Equine Services Corp.** of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions, or for any other use for the benefit of the program.

Signature: _____ Date: _____

Printed Name: _____

LIABILITY RELEASE

I, _____, acknowledge and accept that horseback riding, care and maintenance of animals, and care and maintenance of the ranch grounds and equipment, involve the risk of personal injury. By my signature (and, in case of a minor, the parent's or guardian's signature) they and I, hereby waive all rights, if any, claims, causes of action and lawsuits against KAP Equine Services Corp., their family, heirs, executors, legal representatives, administrators, successors, assigns, guests, employees, or agents affiliated with any of them in any manner (collectively, herein "KAP Equine Services Corp."), for any injury, liability or damages which may occur while performing in any activity on said property. I agree to indemnify, defend, and hold harmless KAP Equine Services Corp., or any person or entity whose land a KAP Equine Services Corp. related activity crosses, for any accident, injury, or loss that might occur, and free such persons from all liability for such injury or loss. I understand activities with animals and/or riding on horses involves possible danger and I participate at my own risk.

I understand that horseback riding and any other activity on the property of KAP Equine Services Corp. related activities involve being in remote areas for extended periods of time, far away from communication, transportation, and medical facilities; that these areas have many natural and man-made hazards which a participant cannot anticipate, identify, modify, or eliminate; that horses and other animals can be excitable, difficult to control, and unpredictable; and that accidents can happen to anyone at any time. I further understand that horseback riding can involve such activities as crossing creeks, galloping over uneven terrain, and being in unfamiliar places under adverse weather conditions which could result in injury to me and/or to the horse I am riding.

I agree to take all responsibility for myself and the animal I am caring for and/or riding. I am aware that wearing a certified safety helmet is a good protective measure against head injury, and further understand that helmets are required for all horse riders. My signature below constitutes acceptance of the above terms and conditions.

Medical Release

I further agree to allow and be financially responsible for any necessary emergency medical treatment by any available physician at any available medical institution in the event of my injury or illness. I have read and fully understand this liability release. I understand that the Texas Equine Liability Act (Chapter 87, Civil Practice and Remedies Code), and KAP Equine Services Corp. is not liable for an injury to or the death of a participant in equine activities resulting in the inherent risks of equine activities.

Print Name

_____

Signature

_____

Date _____

Signature of Guardian if participant is a minor

_____

Street Address

_____

City _____

State _____

Zip _____

Primary phone number

_____

Primary email address

_____