HORSE CAMP - REGISTRATION FORM

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

Name: _____ **Birth Date:** _____ **Age:** _____

Height: _____ **Weight:** _____ **E-mail:** _____

Home/Cell Phone: _____ **Work Phone:** _____

School attending: _____ **2023-2024 Grade:** _____

Legal Guardian/s: _____ **Email:** _____

Place of Employment: _____

In case of emergency, notify: _____

Relationship: _____ **Contact number:** _____

For Office Use Only

Date Application Received: _____

Payment Amount: $_____ (cash/check/card) **Date paid:** _____

Remaining Balance: $ _____

HORSE CAMP - REGISTRATION FORM

Client Name: _____

Horse Camps (Check one) *NO HORSE EXPERIENCE NEEDED FOR EITHER CAMP*

_____ Boys & Girls Horse Camp
Cost: $400
Dates: June 12-16
Times: 9:00am-1:00pm
Ages: 8-12
Activities: Consist of a mix of ground and riding lessons. Subjects include grooming, saddling, feeds and feeding, tack, horse care, horse anatomy and characteristics, balance, cues, and more.
Food: Participants will need to bring a sack lunch. Snacks and water provided.

_____ Fearfully & Wonderfully Made Teen Girls Horse Camp
Cost: $350
Dates: July 10-14
Time: 5:30pm-8:00pm
Ages: 13-15
Activities: Consist of a mix of ground and riding lessons. Subjects are the same as the Boys & Girls Camp. Will also include a time of Biblical truths related to identity and Psalms 139:14.
Food: Participants will need to eat dinner before arriving. Snacks and water provided.

Payment Information
Spots are limited. $200 to reserve a spot. Must be paid in full 2 weeks before the start of camp.
REFUND POLICY: In the event you need to cancel, you must notify us 1 week before camp starts to qualify for a full refund.

Make checks payable to: **KAP Equine Services Corp.**
We also accept cash and can take credit cards over the phone.

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Client Name: _____

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

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

Past and Prospective Surgeries That May Affect Riding (please include date of surgery)

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Client Name: _____

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

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 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: _____

HORSE CAMP - REGISTRATION 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.

Are there any other concerns or information you want us to be aware of before beginning the Horse Camp?

Honesty Declaration:
I, _____, attest that the answers provided throughout this 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

HORSE CAMP - REGISTRATION FORM

Client Name: _____

EMERGENCY MEDICAL TREATMENT

Attending Physician: _____

Phone number: _____

Preferred Medical Facility: _____

Phone number: _____

Health Insurance Company: _____

Name of Policy Holder: _____

Policy #: _____

HORSE CAMP - REGISTRATION 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:** _____

HORSE CAMP - REGISTRATION 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

Executed and signed in the STATE OF TEXAS/COUNTY OF KAUFMAN

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 equine professionals are 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_____

Primary phone number_____

Primary email address_____

RIDER'S MEDICAL HISTORY AND PHYSICIAN STATEMENT

(*This form must be signed by a medical physician.)*

Before being accepted as a rider, it is essential that the questions are thoroughly and completely answered so each rider's abilities and limitations are given due consideration by **KAP Equine Services Corp.'s** trained instructors, the student's physicians, and therapists.

*If this form is being filled out for a **KAP Equine Services Corp.** Horse Camp, a medical athletic release will also be accepted instead of this form.*

Rider's Name: _____ **Birth Date:** _____ **Age:** ___

Diagnosis: _____ **Date of Onset:** _____

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

Tetanus shot: Y / N **Date of shot:** _____

Seizures: Y / N **Controlled:** Y / N **Date of last seizure:** _____

For persons with Down Syndrome
Cervical x-ray for Atlantoaxial Instability
Positive _____ **Negative** _____ **Date of x-ray** _____

Specific body movements or positions NOT to be attempted

Specific body movements or positions desired

TO THE PHYSICIAN: Please indicate if patient has a problem and/or surgeries in any of the following areas by circling yes or no. If yes, please provide a comment.

Area	Yes	No	Comment
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Mental Improvement			
Psychological Impairment			
Pain			
Other			

To my knowledge, there is no reason why this patient cannot participate in supervised equestrian activities. I understand that the therapeutic riding center will weigh the medical information provided against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a

licensed/credentialed health professional (PT, OT, Speech, Psychologist, etc.) in the implementing of any effective equestrian/hippotherapy program.

THIS FORM MUST BE SIGNED BY THE ATTENDING PHYSICIAN. WE CANNOT ACCEPT A SIGNATURE STAMP OR THE SIGNATURE OF ANY THERAPIST, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER. THIS SIGNATURE MUST BE ORIGINAL. A FAX CANNOT BE ACCEPTED.

Physician's Name: _____ **Date:** _____

Physician's Signature: _____ **Phone:** _____

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

If you have any further concerns about this patient participating in Therapeutic Riding sessions, please specify:

_____
_____
_____