FOR OFFICE USE ONLY:			
Registration Photo Release Consent for Release of Information	Rider Requirements Liability Release	Authorization for Emergency Rider/Parent Questionnaire	Medical Treatment Medical History/Physician's Statement



### REGISTRATION

RIDER:		Date of Birth:	Age:
Street:			
	County:		
PARENTS OR GUARDIAN:		Relationsh	ip:
Street:			
	Zip: E-Mail		
Home Phone:	Work Phone:	Cell Phone:	
IN CASE OF EMERGENCY CON	NTACT:		
Name:	Relationship:	Phone:	
Name:	Relationship:	Phone:	
I do I do not	PHOTO RELE	<u>ASE</u>	
consent to and authorize the use and repr taken of me/my son/my daughter/my war activities or for any other use for the bene	rd for promotional printed materia		
Signature:		Date:	
(Parent or Gua	ordian)		

This Registration is conditional upon the execution and delivery of the Liability Release and the Authorization for Emergency Medical Treatment.



### RIDER REQUIREMENTS

**Age:** Victory Gallop offers lessons to children ages 3 up until their 18<sup>th</sup> birthday.

### Disabilities Served:

- Life threatening illnesses
- Children as Risk (i.e. physically and/or sexually abused)
- Children with emotional and/or emotional impairments per the DSM IV

### **Lesson Fees:**

Three sessions are offered each year. Each session runs 12 weeks and costs \$300 to the rider's family.

### **Time Limit:**

### Once a rider is accepted into the program, he/she may participate in Victory Gallop until:

- The individual's therapeutic goals have been achieved.
- Victory Gallop is not able to meet and/or provide effective therapy.
- Rider poses a threat to the welfare and/or safety of himself/herself, Victory Gallop and/or its participants. To be determined by the Board of Directors upon recommendation from the Program Directors and Instructors.
- When a rider misses 3 consecutive lessons without notification to his/her instructor.
- He/she exceeds the 180 lb weight limit.
- He/she turns 18 years of age.

### Forms:

# The rider information packet must be completely filled out by a parent or legal guardian on a yearly basis.

- Registration Form
- Authorization for Emergency Medical Treatment
- Photo Release
- Liability Release
- Medical History/Physician Release (weight limit of 180 pounds)
- Consent for Release of Information
- Rider Requirements

### Parent/Guardian Involvement:

- Parents or legal guardian must attend a parent information meeting prior to the enrollment of his/her child.
- Parent, legal guardian or state approved supervisor must be present during student's lessons.

I have read the above information and understand the guidelines of Victory Gallop.

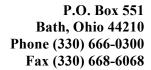
Parent's Signature	Date	



## **AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM**

1	Participant	Staff	Volunteer	
Name:		DOB:	Phon	e:
Address:				
Physician's Name:			cal Facility:	
Health Insurance Company:			Policy #:	
Allergies to medications:				
Current medications:				
In the event of an emergency, contact:				
Name:		Relation	:	Phone:
Name:				
Name:				
treatment.  Consent Plan This authorization includes x-ray, surger "life saving" or necessary to preserve we only be invoked if the person(s) above is	ell being by the p	ohysician and/or de		
Date: Consen	t Signature:			
		(C	lient, Parent or Legal	Guardian)
Non-Consent Plan I do not give my consent for emergency receiving services or while being on the wish the following procedures to take pl	property of the a			
Date: Consen	t Signature:			
DateCuiscii	i bigiiatui c	(C	Client, Parent or Legal	Guardian)

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM.





## PARTICIPANT'S CONSENT FOR RELEASE OF INFORMATION FROM 3<sup>RD</sup> PARTY

I	hereby	authorize:
	(Person or Facility)	
to release in	formation from the records of(Participant's	DOB:
	ation is to be released to <b>Victory Gallop</b> for the purpose e named participant. The information to be released is in	
	Medical History Physical Therapy evaluation, assessment and program Occupational Therapy evaluation, assessment and program pr	olan 1
Signature: _	(Client, Parent or Guardian)	Date:
Print Name:		
Relation to I	Participant:	

Please send the indicated material to:

VICTORY GALLOP, INC. P.O. BOX 551 BATH, OHIO 44210



### **LIABILITY RELEASE**

Please read the following carefully. You are being asked to release us of all liability.

	ment I am stating that I am a legally competent adult 18 years of age or older, reement and release, I fully agree to each of the statements and terms ith the intention to be legally bound thereby.
Signature of Parent or Guardian	Date
applicant to participate in the Program on the terms and of terms of this agreement and release, I fully agree to each	the parent or legal guardian of the above Participant and consent to allow the conditions set forth above. I have carefully read and understood each of the of the statements and terms contained herein, and I am signing as my own ticipant, and all heirs, successors, assigns, executors, estates and personal icipant and myself, to all of the terms hereof.
	or her heirs, successors, assigns, executors, estate and personal e that it is and will be binding on them as well as Participant.
	and strictly follow all instructions given during the course of participation. s, it is the decision of the Victory Gallop, Inc. whether or not Participant may at decision.
observes the Program, and in consideration for Participal fully discharge Victory Gallop, Inc., its agents, employed trustees, guests and other participants, as the case may be Irrevocable Trust, David Miller, Susan Miller, and Kim all liability, injuries, damages, claims, demands or action Activities. I also agree to indemnify and hold harmless judgments, costs, and losses of any kind, including reaso brought against them as a result of the Participant's particularly licensed as doctors of medicine or doctors of dentistic	illness or damage that might be sustained while Participant participates in of ant being allowed to participate in the Program, I hereby forever release and ees, instructors, guest instructors, therapists, aides, volunteers, members, be, including but not limited to the David M. and Susan J. Miller berly Gustely (collectively, the "Released Parties"), from and for any and ons in any way arising out of or related to Participant's participation in the the Released Parties for and from any and all claims, liabilities, expenses, nable attorney's fees, which may be incurred in connection with any action cipation in the Program. I hereby authorize physicians, dentists, and staff, try or other such licensed technicians or nurses, to perform any diagnostic eatment in the event of Participant's injury, accident and/or illness during ll cost and burden of such treatment.
associated with horses and stables (the "Activities") corowned and/or operated by Victory Gallop, Inc. and The Program's Activities involve exercise and personal body	(print name) (sometimes hereafter referred to as the "Participant"), k riding and training program and/or any other horse related activities inducted by Victory Gallop, Inc. (the "Program") on or about the premises David M. and Susan J. Irrevocable Trust. I fully understand that the contact, and that there are risks and dangers to the Participant and to others odily injury, disability, paralysis and death. I also understand that there are ld arise.

WARNING! BY SIGNING THIS RELEASE YOU ARE GIVING UP YOUR RIGHTS TO SUE OR OTHERWISE RECOVER DAMAGES FROM THE RELEASED PARTIES REGARDLESS OF ANY NEGLIGENCE, WRONGDOING OR FAULT OF THE RELEASED PARTIES.



## RIDER/PARENT QUESTIONNAIRE AND HEALTH HISTORY

Rider Name:			
Reasons for involvement	ent in	Vict	ory Gallop:
What accomplishmen	ts wo	ould	you like to see your child achieve through his/her participation in Victory
Gallop:			
Please indicate curre	nt or	nast	special needs in the following systems/areas:
Trease muleate curre	Y	N	Comments
Vision	1	11	Comments
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Circulation			
Emotional/Mental			
Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			
Will you be applying f	for a I	Ride	Scholarship: Yes No
			an be willing to volunteer? Yes No
- <b>-</b>	_		
Signature:			Date:



Date:			
Dear Health Care Provider:			
Your Patient,			
is interested in participating in superv	vised equine activities.		

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

#### **Orthopedic**

Atlantoaxial Instability – include neurologic symptoms Coxa Arthrosis Cranial Deficits Heterotopic Ossification/Myositis Ossificans Joint subluxation/dislocation Osteoporosis Pathologic Fractures Spinal Fusion/Fixation Spinal Instability/Abnormalities

### Neurologic

Hydrocephalus/Shunt Seizure Spina Bifida/Chiari II malformation/Tethered Cord Hydromyelia

### Other

Age – under 4 years **Indwelling Catheters** Medications – i/e/ photosensitivity Poor Endurance Skin Breakdown

### Medical/Psychological

Allergies Animal Abuse Physical/Sexual/Emotional Abuse **Blood Pressure Control** Dangerous to self or others Exacerbations of medical conditions Fire Settings **Heart Conditions** Hemophilia Medical Instability Migraines PVD Respiratory Compromise Recent Surgeries Substance Abuse **Thought Control Disorders** 

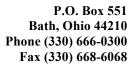
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,

Susan J. Miller, M.Ed. Co-Director

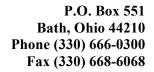
Kimberly A. Gustely, M.S. Co-Director





## RIDER'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Name				Date of Birth	
Street		City		State _	Zip
Name of Parent/Guardian	ı				
DIAGNOSIS:			J	Date of Onset:	
Riders with DOWN SY	NDROMI	E: Neurologic Exam does not	t reveal AAI or fo	cal neurologic (	disorder. Yes No
Height Weight ( <b>M</b> Seizure Type	aximum 1	180 lbs. for enrollment) Controlled Y N	_ Tetanus Shot Date of L	Y N Dat ast Seizure	te
Allergies					
Please indicate current or pas		eeds in the following systems/areas,	including surgeries:		
	Y N	Comments			
Auditory Visual	+	<u> </u>			
Visual	+				
Tactile Sensation					
Speech	+	<del> </del>			
Cardiac					
Circulatory					
Integumentary/Skin	<del></del>				
Immunity Pulmonomy					
Pulmonary					
Neurologic Museuler					
Muscular	<del></del>				
Balance Orthopodia	<del></del>				
Orthopedic	<del></del>				
Allergies	<del></del>				
Learning Disability	<del></del>	-			
Cognitive Emotional/Psychological	+	+			
Pain	<del></del>	+			
Other	<del></del>	+			
Other					
NARHA center will weigh the	e medical in y a licensed/	ny this person cannot participate in information above against the existin d/credentialed health professional (e.g.	ng precautions and con-	ntradictions. I conc	cur with a review of this
Name/Title (please print)			M	D DO NP PA	Other
Signature				Date	
Address		Ci	.ty	State	Zip
Phone Number			License/UPIN Nur	nber	





## REQUEST FOR RIDER SPONSORSHIP

Rider's Name:	
Parent/Guardian:	
Address:	
Number of adults in household:	
Number of children in household:	
Names and ages:	
Place of Employment:	How Long:
What is your monthly rent or mortgage payment?	
How many vehicles do you own? Model & Year:	
Approximate total monthly family income:	
Approximate total monthly expenses (rent, mortgage, car pay	yments, insurance, utilities, credit cards, etc.):
Please feel free to provide any additional information that wi funding.	
I am currently unable to pay the entire amount of \$300 for \$ per session and request a Rider Sponsors	
Signature:	Date: