



# AGAPÉ THERAPEUTIC RIDING CENTER

24970 MT. PLEASANT RD.  
CICERO, IN 46034  
PHONE (317) 773-7433  
FAX (317)984-9103

## INFORMATION AND RELEASE FORM

Client: \_\_\_\_\_ Male / Female      Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ School or Institution presently attending: \_\_\_\_\_  
Email: \_\_\_\_\_

Mother/Guardian: \_\_\_\_\_ Place of Employment: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_  
Father/ Guardian: \_\_\_\_\_ Place of Employment: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_  
Parent/Guardian Address (if different) \_\_\_\_\_

### In Case of Emergency

Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_ Relationship: \_\_\_\_\_

### **Liability Release**

\_\_\_\_\_ (Client's Name) would like to participate in the Agapé Therapeutic Riding Program. I acknowledge the risks and potential for the risks of horseback riding. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself: my heirs and assigns, executors or administrators, waive and release forever all claims to damages against Agape Therapeutic Riding, its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees, as well as for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Agape Therapeutic Riding.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Parent, Guardian or Client (over 18 years of age)

### Photo Release:

*I hereby consent to and authorize the use and reproduction by Agapé Therapeutic Riding of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, media, website or for any other use for the benefit of the program.*

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Parent, Guardian or Client (over 18 years of age)

### Photo Non-Consent Signature:

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Parent, Guardian or Client (over 18 years of age)

(THIS FORM IS TO BE UPDATED ANNUALLY)

**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  
HORSE  
COUNCIL



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## Authorization for Emergency Medical Treatment

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 Agape Therapeutic Riding Resources Inc. 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.

Client's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

In the event I cannot be reached, Contact: \_\_\_\_\_ Phone \_\_\_\_\_

Contact: \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

### 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 listed is unable to be reached.

Date: \_\_\_\_\_ Consent Signature \_\_\_\_\_

(Client (over 18 yrs. of age), Parent or Guardian)

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

### 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. In the event emergency treatment aid is required, I wish the following procedures to take place:

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Date: \_\_\_\_\_ Non-Consent Signature: \_\_\_\_\_

(Client (over 18 yrs. of age), Parent or Guardian)

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

# Agape Therapeutic Riding Center Health History/Physician Release

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Form Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Student Phone \_\_\_\_\_ Parent/Guardian Phone \_\_\_\_\_  
 Name of Parent/Guardian \_\_\_\_\_ Address \_\_\_\_\_  
 Diagnosis \_\_\_\_\_ Date of Onset \_\_\_\_\_  
 Medical History (Include Surgeries and Dates) \_\_\_\_\_  
 \_\_\_\_\_  
 Medications \_\_\_\_\_  
 Allergies \_\_\_\_\_  
 Tetanus Shot No Yes Date of Shot \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ (over 170 lbs must have prior authorization)

\*\*\*FOR PERSONS WITH DOWNS SYNDROME\*\*\* Full Flexion and Extension X-rays for Atlantoaxial. Instability (AAI) is required within 5 years prior to entering Agape Therapeutic Riding Center. Annual physical examination should reveal no symptoms of AAI. Follow-up X-rays should be every 10 years after. **NO INDIVIDUAL MAY RIDE WITH POSITIVE SYMPTOMS OF AAI.** Cervical X-ray for AAI Negative \_\_\_\_\_ Date \_\_\_\_\_ Doctor's Initial \_\_\_\_\_

Please circle NO or YES for each of the following conditions. **Presence of a condition may or may not be appropriate to receive riding or driving instruction. Further information may be necessary.**

Spinal Fusion	No	Yes	Location & Type _____
Spinal Instabilities/ Abnormalities	No	Yes	Location & Type _____
Spinal Orthoses	No	Yes	Location & Type _____
Internal Spinal Stabilization Devices	No	Yes	Location & Type _____
Scoliosis	No	Yes	Location & Type _____
Kyphosis/Lordosis	No	Yes	Location & Type _____
Hip subluxation/Dislocation	No	Yes	Describe _____
Osteoporosis	No	Yes	Type & Degree _____
Pathologic Fractures	No	Yes	Type & Degree _____
Coxas Arthrosis	No	Yes	_____
Arthritis	No	Yes	Location _____
Heterotopic Ossification	No	Yes	_____
Oseogenesis Imperfecta	No	Yes	_____
Cranial Deficits	No	Yes	_____
Hydrocephalus/Shunt	No	Yes	Location _____
Cerebral Palsy	No	Yes	Type _____
Spina Bifida	No	Yes	Location & Degree _____
Tethered Cord	No	Yes	Degree _____
Chiari II Malformation	No	Yes	Degree _____
Hydromyalia	No	Yes	_____
Spinal Cord Injury	No	Yes	Location & Degree _____
Paralysis	No	Yes	Location & Degree _____
Seizures	No	Yes	Type _____ Date of Last Seizure _____
Controlled with Meds	No	Yes	Medication _____
Cancer	No	Yes	Type & Location _____
Poor Endurance	No	Yes	Degree _____
Diabetes	No	Yes	Type _____
Peripheral Vascular Disease	No	Yes	Location & Type _____
Varicose Veins	No	Yes	Location and Type _____
Hemophilia	No	Yes	_____
Hypertension	No	Yes	_____
Serious Heart Condition	No	Yes	Location & Type _____
Stroke (CVA)	No	Yes	Location, type, result _____
Aneurysm	No	Yes	Location, result _____
Known embolus	No	Yes	_____
Known thrombus	No	Yes	_____

Surgeries	No	Yes	Location, type, date _____
Indwelling Catheter	No	Yes	_____
Chronic Pain	No	Yes	Location & Degree _____
Internal-Pumps	No	Yes	Location & Type _____
G-tube	No	Yes	Location & Type _____
Pacemaker	No	Yes	Location & Type _____
Colostomy	No	Yes	Location & Type _____
Other	No	Yes	_____
Auditory Difficulties _____			Vision _____
Behavior Difficulties _____			Psychological _____
Emotional Difficulties _____			Incontinence _____
Postural Muscle Tona _____			Spasticity/Rigidity _____
Neuro-Sensation _____			Circulation _____
Contractures _____			Braces _____
Wheelchair _____ Walker _____			Cane/Crutches _____
General Health _____			_____
Additional pertinent information about this individual (pregnancy, etc.) _____			
_____			

**To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the NARHA center will evaluate the medical information that has been provided in relation to the existing NARHA precautions and contraindications. I concur with a review of this person's abilities/limitation by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc), in the implementation of an effective equine activity program.**

**Name/Title (please print)** \_\_\_\_\_ **MD DO NP PA Other** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone ( )** \_\_\_\_\_ **Date** \_\_\_\_\_

Please return this form to: Agape Therapeutic Riding Center  
 24970 Mt. Pleasant Rd. Phone (317) 773-7433  
 P.O. Box 207 Fax (317) 984-9103  
 Cicero, IN 46034-0207

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# Agape Therapeutic Riding Resources, Inc.

## STUDENT/CLIENT PROFILE

Name: \_\_\_\_\_ Approximate Weight: \_\_\_\_\_ Age: \_\_\_\_\_

General Disability: \_\_\_\_\_ Mental Age: \_\_\_\_\_  
(i.e., cerebral palsy, spina bifida, downs syndrome, etc.)

### CHECK WHERE APPROPRIATE

- Ambulatory       Non-Ambulatory
- Wheelchair       Power       Manual       Walker
- Walks with assistance (explain) \_\_\_\_\_
- Able to bear weight ( With/Without) Assistance
- Able to maintain a sitting position without support
- Tactile defensive
- Tight adductors (interior thigh muscles)
- Seizures
  - Frequency \_\_\_\_\_ Typical Duration \_\_\_\_\_
  - Type of Seizures \_\_\_\_\_ Post Seizure Activity \_\_\_\_\_
  - Managed by Medication \_\_\_\_\_
- Visually impaired
  - Partial vision       Total vision impairment
- Hearing impaired
  - Partial hearing       Total hearing impairment       Hearing Aids
- Verbal
- Non-verbal       Uses sign language       Uses communication board
- Behavior Problems
  - Screams     Pinches     Bites       Pulls Hair       Bangs Head
  - Kicks       Other (explain) \_\_\_\_\_

### **DOES YOUR RIDER HAVE/USE:**

- Shunt (location) \_\_\_\_\_
- Braces (explain) \_\_\_\_\_

\*\*Note that any participant with a lack of sensitivity in the lower extremities needs to watch for possible pressure sores. Sitting on a horse is a different position than sitting in a chair \*\*