REIN AND SHINE
@ Windwood Farm
4857 Windwood Farm Road
Awendaw,SC 29429
(843) 849-0964
www.reinandshine.org

Veteran Program Application

A PATH PREMIERE ACCREDITED FACILITY
(Professional Association of Therapeutic Horsemanship Intl)

***Application must be completed and returned to Rein and Shine prior to student's first riding lesson.**

Please Mail Completed Applications to:
Rein & Shine
5220 Bedaw Farm Rd.
Awendaw SC 29429

Veteran Program Application

In order to ensure safety and coordinated care, Rein and Shine staff and volunteers are provided with information about participant's abilities/disabilities.

Date of Application _____ Participant's Name_____

Circle one: Active Duty / Reserve / Guard / Veteran Branch_____

Primary Diagnosis: _____

Height: _____ Weight:_____

Date of Birth _____ Age _____ Male Female

Street _____ City _____ State_____ Zip_____

Email address_____

Please List Participant's Phone Numbers:

Home _____ Contact (if other)_____

Work _____ Contact (if other) _____

Cell _____ Contact (if other) _____

How did you hear of our program?

_____

Do you have any experience with horses? Please explain:

_____

_____

Do you have any concerns about participating in the program?

_____

_____

Please list any goals you would like to achieve while riding at Rein and Shine:

_____

_____

Is there any other information you would like to share with us that will help you get the most out of your session?

_____

_____

PARTICIPANT'S CONSENT & RELEASE FORM
CONSENT FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury while participating in the services of, or while being on the property of Rein and Shine ("R&S"), I authorize R&S to secure and retain medical treatment and/or transportation if needed. This authorization includes any treatment deemed necessary by a treating health care professional and includes but is not limited to x-ray, surgery, hospitalization, and medication. In addition, I authorize R&S to release my/my child's records to any individual involved in medical treatment and/or necessary transportation.

Participant's Name _____

In case of emergency:

Contact_____

Phone_____

Contact_____

Phone_____

Physician's Name_____

Phone_____

Health Insurance Name (optional) _____

Policy #_____

Date_____

Participant Signature _____

LIABILITY RELEASE

Under South Carolina 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.

_____ (Participant's name)
would like to participate in the Rein and Shine Therapeutic Riding Program. I acknowledge the risks and potential for risks in riding and working with horses. However, I feel that the possible benefits to me are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs, assigns, executors and/or administrators, waive and release forever all claims for damages against Rein and Shine, its Board of Directors, Advisory Board, Instructors, Therapists, Aides, volunteers, employees, agents, and representatives of any kind for any and all injuries, damages, claims, demands, causes of actions, law suits, and/or losses I may sustain while participating in Rein and Shine's Therapeutic Riding Program.

Participant's Signature_____ Date _____

PHOTO & PUBLICITY RELEASE (Optional):

I hereby consent to and authorize Rein and Shine to use my name in all audio, visual and written promotional material and to use and/or reproduce any and all photographs and any other audiovisual materials taken of me for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.

Participant's Signature_____ Date _____

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Awendaw SC 29429

Dear Healthcare Provider:

Your patient is interested in participating in supervised equine activities. In order to safely provide this service, we request that you complete (or update) the attached Participant Medical History and Physician's statement. 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
__Spina Bifida/Chiari II Malformation/Tethered Cord/
Hydromyelia
__Medical/Psychological
__Allergies
__Animal Abuse
__Physical/Sexual/Emotional Abuse
__Blood Pressure Control
__Dangerous to self or others
__Exacerbations of medical conditions
__Fire Setting
__Heart Condition
__Hemophilia
__Medical Instability
__Medications– e.g. photosensitivity
__Migraines
__PVD
__Poor Endurance

PARTICIPANT'S MEDICAL HISTORY
& PHYSICIAN STATEMENT
(To be completed by physician)

Participant's Name_____ Date of Birth _____

Address_____ Home Phone _____

Height _____ Weight _____

Medications_____
_____
_____

History of Seizures? Y N If so, what type? _____ Controlled?_____

Please list current or past indications/special needs, including surgeries:

AREAS	***YES***	***NO***	***COMMENTS***
Visual			
Auditory			
Tactile Sensation			
Speech & Language			
Cognitive/Processing			
Learning & Development			
Psychological/Emotional/ Behavioral			
Muscular			
Balance			
Orthopedic – Note Scoliosis or Hip Subluxation/Dislocation			
Neurologic			
Cardiac			
Circulatory			
Pulmonary			
Integumentary/Skin			
Immunity			
Pain			
Allergies			

Other_____
_____

To my knowledge, there is no reason this person cannot participate in supervised equestrian activities.

Name & Title (print) _____MD DO NP PA

Phone _____

Address (City State Zip) _____

Signature_____ Date _____

Certification & Authorization

I certify that the information I have provided is true and complete to the best of my knowledge. I understand that misrepresentation, falsification, or omission of information may disqualify me from further consideration as a student, or may result in my dismissal.
If accepted as a student, I understand that I must abide by all Rein and Shine policies, rules and regulations.
I authorize Rein and Shine to investigate all statements contained in this application and to make inquiries of my medical history, as well as other matters as may be necessary for determining my eligibility as a student. I hereby release physicians, employers, schools or individuals from all liability in responding to inquiries relating to my student application.

_____ _____
Signature of Student or Guardian Date

If Student cannot legally sign for him or her self, then Legal Guardian must sign below.

_____ _____
Legal Guardian of Adult Student Date

Thank You!