REIN AND SHINE
5220 Bedaw Farm Dr
Awendaw, SC 29429
(843)849-0964 Ph
(843)849-1012 Fax
www.reinandshine.org

Participant Application Horsemanship Riding Lessons

A PATH PREMIERE ACCREDITED FACILITY

(Professional Association of Therapeutic Horsemanship Intl)

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

REIN AND SHINE THERAPEUTIC RIDING ORGANIZATION
5220 BEDAW FARM DRIVE AWENDAW, S.C. 29429
(843)849-0964 FAX (843)849-1012
www.reinandshine.org

PARTICIPANT APPLICATION

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

Participant's Name_____

Date of Birth _____ Age _____ Male ☐ Female ☐

Street _____ City _____ State_____ Zip_____

Email address _____

School Name _____

Parent or Guardian Name(s) _____

Rider or Guardian's Employer _____

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? _____

_____

_____

Personality Profile

Please describe personality and strengths:

_____

_____

_____

What are some favorite activities and/or topics?

_____

_____

_____

What are some fears and/or dislikes?

_____

_____

_____

Our Family's Do's and Don'ts:

_____

_____

Any other special things we should know? _____

_____

_____

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

_____

_____

_____

This form was completed by (participant/parent/other):

_____ _____

Name **Date**

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 _____

(or signature of parent/guardian if participant is under age 18)

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/my child/my ward 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/my child/my ward may sustain while participating in Rein and Shine's Therapeutic Riding Program.

Date _____

Participant's Signature_____
(Or signature of parent/guardian if participant is under age 18)

PHOTO & PUBLICITY RELEASE (Optional):

I hereby consent to and authorize Rein and Shine to use my/my child's/my ward's 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/my child/my ward for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.

Participant's Signature_____

(or signature of parent/guardian if participant is under age 18)

Date _____

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 _____

Name of Parent(s)/Guardian(s) _____

_____

Height _____ Weight _____ Medications_____

_____

_____

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**