

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
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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