2020-2021

Participant's Updated Information

Participant: _____

Parent/Caregiver/Guardian: _____

Caregivers: _____

Address: _____

Phone: _____ Email: _____

Alternative Phone Contact: _____

Employer: _____Phone: _____

HEALTH HISTORY

Diagnosis: _____ Age_____ DOB _____

Date of Onset: _____

Changes: (i.e. medications/behavioral) _____

GOALS What would you like rider to accomplish through riding?

_____

_____

_____

Signature: _____ Date: _____

PHOTO RELEASE

I ❑ DO ❑ DO NOT consent to and authorize the use and reproduction by Turning Point Ranch Therapeutic Riding Center of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Client, Parent or Legal Guardian

2020-2021

Rider Liability Release Form

Release of Liability: _____, would like to participate in the Turning Point Ranch Therapeutic Horseback Riding program.

By my signature below, I (or parent/caregiver/guardian for participants under 18) acknowledge that I am aware of the risks and potential risks of riding and involvement with horses.

I hereby, intending to be legally bound for myself, my heirs, and assigns, executors or administrators do waive and release forever all claims of damages against Turning Point Ranch, its Board of Directors, Instructors, Therapists, Aides, Volunteers, landowners, and employees from any and all liability and claims of any nature whatsoever, *including taking action to control, restrain or confine the undersigned for the safety and protection of the undersigned or others* and any damages whatsoever (including costs, expenses and attorney's fees) that might result from damages, injuries, or losses to their person or property during or in connection with, or arising out of any class, lesson, demonstration, show, clinic, event or other function.

I understand that under Oklahoma Law, an equine activity sponsor or professional shall not be liable for any injury to or the death of a participant or equine in equine activities resulting from the inherent risks of equine activities.

In exchange for the use of property under the control of Turning Point and other valuable consideration, I agree that my use of the premises and any animals, property or equipment under the control of Turning Point is at my own risk. I agree to indemnify and hold harmless Turning Point, its officers, members, employees, volunteers and agents from any and all suits, actions or claims of any type arising from my use of the premises or equipment or participation in an equine activity or of such use or participation by a guest of mine whether or not such claims result directly from the negligent act or omissions of the indemnified parties or otherwise.

I further acknowledge that I have read this agreement and fully understand its content.

AGREED:_____ Date: _____

Signature of adult rider or parent/guardian/caretaker of minor rider

Date: _____

Dear Health Care Provider:

Your patient _____

(participant's name)

has been participating in supervised equine activities at **Turning Point Ranch Therapeutic Riding Center** and is due for an update of his/her medical status.

Please review the previous medical history and provide an update of the information in the space below. Address occurrences over the past year including surgeries, illnesses, hospitalizations, changes in medications, treatment, weight or behavior.

Please indicate current height/weight.

If this person has Down syndrome or any other condition that predisposes him/her to Atlantoaxial Instability, please include results of his/her neurologic exam.

Diagnosis: _____

Height: _____ Weight: _____ **NOTE: 185 pound weight limit**

Update Status:

_____

_____

_____

_____

_____

_____

_____

_____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that the PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____

MD DO NP PA Other _____

Signature: _____Date: _____

Address: _____

Phone: ( ) License/UPIN Number: _____