Sky Riding LI

Dressage · Therapeutic Riding · Jumping

Participant's Application & Release Form

E-Mail this form to: *Nancy.Tejo@SkyRidingLI.com*

GENERAL INFORMATION

Participant:_____

DOB: _____Age: _____Height: _____Weight: _____Gender: M F

Address: _____

Phone: _____Email: _____Alternative #: _____

Employer/School: _____

Parent/Legal Guardian: _____

Caregivers: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

Phone: _____

How did you hear about Sky Riding LI? _____

HEALTH HISTORY

Diagnosis: _____Date of Onset: _____

Please indicate current or past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

MEDICATIONS (include prescription and over-the-counter; name, dose and frequency) _____

_____

_____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):
PHYSICAL FUNCTION (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding) _____

_____

_____

_____

_____

PSYCHO/SOCIAL FUNCTION (e.g.,. work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

_____

_____

_____

_____

GOALS (i.e. why are you applying for participation? What would you like to accomplish?_____

_____

_____

_____

Signature: _____Date: _____

❑LIABILITY RELEASE

_____ would like to participate in the Sky Therapeutic Riding LI program. I acknowledge the risks and potential for 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 bond, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Sky Therapeutic Riding LI, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating at Sky Therapeutic Riding LI.

Signature: _____ Date: _____
Client, Parent or Legal Guardian

❑24 HOUR CANCELATION NOTIFICATION POLICY

A 24-hour cancelation notification is required to cancel a lesson/session without incurring a fee. If a cancelation is made less than 24 hours before a scheduled lesson/session I understand that I am responsible to pay the cancelation fee of $60.00. Signature: _____Date_____
Client, Parent or Legal Guardian

PHOTO RELEASE

I ❑ DO

❑ DO NOT

consent to and authorize the use and reproduction of any and all photographs and any other audio/visual materials taken of me by Sky Riding LI for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Client, Parent or Legal Guardian