FOR OFFICE USE ONLY:
_____ Registration _____ Photo Release _____ Rider Requirements _____ Authorization for Emergency Medical Treatment
_____ Consent for Release of Information _____ Liability Release _____ Rider/Parent Questionnaire _____ Medical History/Physician's Statement

P.O. Box 551
Bath, Ohio 44210
Phone (330) 666-0300
Fax (330) 668-6068

REGISTRATION

RIDER: _____ **Date of Birth:** _____ Age: _____

Street: _____

City: _____ County: _____ Zip: _____

PARENTS OR GUARDIAN: _____ Relationship: _____

Street: _____

City: _____ Zip: _____ E-Mail: _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

IN CASE OF EMERGENCY CONTACT:

Name: _____ Relationship:_____ Phone: _____

Name: _____ Relationship:_____ Phone: _____

PHOTO RELEASE

____ I do
____ I do not

consent to and authorize the use and reproduction by Victory Gallop of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, social media (i.e. facebook, website), media, educational activities or for any other use for the benefit of the program.

Signature: _____ Date: _____

(Parent or Guardian)

This Registration is conditional upon the execution and delivery of the Liability Release and the Authorization for Emergency Medical Treatment.

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RIDER REQUIREMENTS

Age: Victory Gallop offers lessons to children ages 3 up until their 18th birthday.

Disabilities Served:

- Life threatening illnesses
- Children as Risk (i.e. physically and/or sexually abused)
- Children with emotional and/or emotional impairments per the DSM IV

Lesson Fees:
Three sessions are offered each year. Each session runs 12 weeks and costs $300 to the rider's family.

Time Limit:
Once a rider is accepted into the program, he/she may participate in Victory Gallop until:

- The individual's therapeutic goals have been achieved.
- Victory Gallop is not able to meet and/or provide effective therapy.
- Rider poses a threat to the welfare and/or safety of himself/herself, Victory Gallop and/or its participants. To be determined by the Board of Directors upon recommendation from the Program Directors and Instructors.
- When a rider misses 3 consecutive lessons without notification to his/her instructor.
- He/she exceeds the 180 lb weight limit.
- He/she turns 18 years of age.

Forms:

The rider information packet must be completely filled out by a parent or legal guardian on a yearly basis.

- Registration Form
- Authorization for Emergency Medical Treatment
- Photo Release
- Liability Release
- Medical History/Physician Release (weight limit of 180 pounds)
- Consent for Release of Information
- Rider Requirements

Parent/Guardian Involvement:

- Parents or legal guardian must attend a parent information meeting prior to the enrollment of his/her child.
- Parent, legal guardian or state approved supervisor **must be present during student's lessons**.

I have read the above information and understand the guidelines of Victory Gallop.

Parent's Signature Date

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

_____ Participant _____ Staff _____Volunteer

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of Victory Gallop, Inc. and/or the David M. and Susan J. Miller Irrevocable Trust, I authorize **Victory Gallop, Inc. and any of its representatives** to:

1. Secure and retain medical or dental treatment and transportation if needed; and
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan
This authorization includes x-ray, surgery, hospitalization, medication and any diagnostic treatment procedure deemed "life saving" or necessary to preserve well being by the physician and/or dentist, as the case may be. This provision will only be invoked if the person(s) above is unable to be reached.

Date: _____ Consent Signature: _____
(Client, Parent or Legal Guardian)

Non-Consent Plan
I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event that emergency treatment/aid is required, I wish the following procedures to take place:

_____
_____
_____
_____

Date: _____ Consent Signature: _____
(Client, Parent or Legal Guardian)

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM.

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PARTICIPANT'S CONSENT FOR RELEASE OF INFORMATION FROM 3RD PARTY

I hereby authorize:

_____
(Person or Facility)

to release information from the records of _____ DOB: _____
(Participant's Name)

The information is to be released to **Victory Gallop** for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

_____ Medical History
_____ Physical Therapy evaluation, assessment and program plan
_____ Occupational Therapy evaluation, assessment and program plan
_____ Speech Therapy evaluation, assessment and program plan
_____ Mental Health diagnosis and treatment plan
_____ Individual Habilitation Plan (I.H.P.)
_____ Classroom Individual Education Plan (I.E.P.)
_____ Psychosocial evaluation, assessment and program plan
_____ Cognitive-Behavioral Management Plan
_____ Other: _____

Signature: _____ Date: _____
(Client, Parent or Guardian)

Print Name: _____

Relation to Participant: _____

Please send the indicated material to:

VICTORY GALLOP, INC.
P.O. BOX 551
BATH, OHIO 44210

VICTORY GALLOP

P.O. Box 551
Bath, Ohio 44210
Phone (330) 666-0300
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LIABILITY RELEASE

Please read the following carefully. You are being asked to release us of all liability.

This hereby acknowledges that _____ (print name) (sometimes hereafter referred to as the "Participant"), is applying for registration to participate in the horseback riding and training program and/or any other horse related activities associated with horses and stables (the "Activities") conducted by Victory Gallop, Inc. (the "Program") on or about the premises owned and/or operated by Victory Gallop, Inc. and The David M. and Susan J. Irrevocable Trust. I fully understand that the Program's Activities involve exercise and personal body contact, and that there are risks and dangers to the Participant and to others inherent in the Activities including, but not limited to, bodily injury, disability, paralysis and death. I also understand that there are other risks not known or foreseeable at this time that could arise.

I hereby agree to assume and accept all risks of injury, illness or damage that might be sustained while Participant participates in or observes the Program, and in consideration for Participant being allowed to participate in the Program, I hereby forever release and fully discharge Victory Gallop, Inc., its agents, employees, instructors, guest instructors, therapists, aides, volunteers, members, trustees, guests and other participants, as the case may be, including but not limited to the David M. and Susan J. Miller Irrevocable Trust, David Miller, Susan Miller, and Kimberly Gustely (collectively, the "Released Parties"), from and for any and all liability, injuries, damages, claims, demands or actions in any way arising out of or related to Participant's participation in the Activities. I also agree to indemnify and hold harmless the Released Parties for and from any and all claims, liabilities, expenses, judgments, costs, and losses of any kind, including reasonable attorney's fees, which may be incurred in connection with any action brought against them as a result of the Participant's participation in the Program. I hereby authorize physicians, dentists, and staff, duly licensed as doctors of medicine or doctors of dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment, operative procedures, and x-ray treatment in the event of Participant's injury, accident and/or illness during participation in the Program. Participant will bear the full cost and burden of such treatment.

Participant will strictly abide by the rules of the Program and strictly follow all instructions given during the course of participation. Should Participant break any of these rules or instructions, it is the decision of the Victory Gallop, Inc. whether or not Participant may continue in the Program, and Participant will abide by that decision.

This agreement is made on behalf of Participant and his or her heirs, successors, assigns, executors, estate and personal representatives, of any nature, and I understand and agree that it is and will be binding on them as well as Participant.

If Participant is under 18: I, the undersigned, am the parent or legal guardian of the above Participant and consent to allow the applicant to participate in the Program on the terms and conditions set forth above. I have carefully read and understood each of the terms of this agreement and release, I fully agree to each of the statements and terms contained herein, and I am signing as my own free act with the intention to legally bind myself, the Participant, and all heirs, successors, assigns, executors, estates and personal representatives, of any and every nature, of both the Participant and myself, to all of the terms hereof.

_____ _____
Signature of Parent or Guardian Date

If Participant is 18 or over: In signing this agreement I am stating that I am a legally competent adult 18 years of age or older, I have read carefully and understand the terms of this agreement and release, I fully agree to each of the statements and terms contained herein, and I am signing as my own free act with the intention to be legally bound thereby.

_____ _____
Signature Date

WARNING! BY SIGNING THIS RELEASE YOU ARE GIVING UP YOUR RIGHTS TO SUE OR OTHERWISE RECOVER DAMAGES FROM THE RELEASED PARTIES REGARDLESS OF ANY NEGLIGENCE, WRONGDOING OR FAULT OF THE RELEASED PARTIES.

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RIDER/PARENT QUESTIONNAIRE AND HEALTH HISTORY

Rider Name: _____

Reasons for involvement in Victory Gallop:

_____

_____

_____

What accomplishments would you like to see your child achieve through his/her participation in Victory Gallop:

_____

_____

_____

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

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

Will you be applying for a Rider Scholarship: Yes_____ No_____
Would you as the parent/guardian be willing to volunteer? Yes_____ No_____

Signature:_____Date: _____

VICTORY GALLOP

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Date: _____

Dear Health Care Provider:

Your Patient, _____
is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. 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
Seizure
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 Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Other
Age – under 4 years
Indwelling Catheters
Medications – i/e/ photosensitivity
Poor Endurance
Skin Breakdown

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,

Susan J. Miller, M.Ed.
Co-Director

Kimberly A. Gustely, M.S.
Co-Director

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RIDER'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Name _____ Date of Birth _____

Street _____ City _____ State _____ Zip _____

Name of Parent/Guardian _____

DIAGNOSIS: _____ Date of Onset: _____

Riders with DOWN SYNDROME: Neurologic Exam does not reveal AAI or focal neurologic disorder. Yes No

Height _____ Weight (**Maximum 180 lbs. for enrollment**) _____ Tetanus Shot Y N Date _____
Seizure Type _____ Controlled Y N Date of Last Seizure _____

Allergies _____

Current Medications _____

Special Precautions/Needs _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the NARHA center will weigh the medical information above against the existing precautions and contradictions. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementation of an effective equine activity program.

Name/Title (please print) _____MD DO NP PA Other _____

Signature _____ Date _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ License/UPIN Number _____

VICTORY GALLOP

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REQUEST FOR RIDER SPONSORSHIP

Rider's Name: _____

Parent/Guardian: _____

Address: _____

Number of adults in household: _____

Number of children in household: _____

Names and ages: _____

Place of Employment: _____ How Long: _____

What is your monthly rent or mortgage payment? _____

How many vehicles do you own? _____ Model & Year: _____

Approximate total monthly family income: _____

Approximate total monthly expenses (rent, mortgage, car payments, insurance, utilities, credit cards, etc.):
_____

Please feel free to provide any additional information that will assist in assessing your request for sponsorship funding.
_____
_____
_____
_____
_____
_____
_____

I am currently unable to pay the entire amount of $300 for one 12-week riding session. I am able to pay $_____ per session and request a Rider Sponsorship in the amount of $_____.

Signature: _____ Date: _____