T.E.A.D. – EQUESTRIAN ASSOCIATION FOR THE DISABLED

RIDER MEDICAL INFORMATION (Please print)

Name: _____ Birth Date: _____

Address: _____ City: _____

Postal Code: _____ Telephone: Day _____ Evening _____

Sex: _____ Age: _____ Height: _____ ****Weight**:** _____
(must be filled in)

PLEASE NOTE WEIGHT LIMIT: 170 POUNDS or 75 KILOGRAMS

Attending school at: _____ City: _____

Next of Kin: _____ Phone #: _____

Involved in ongoing therapy: Yes ( ) No ( ) Where: _____

Physiotherapist's name: _____

MEDICAL

Primary Diagnosis: _____

Secondary Diagnosis: _____

Name and Date of significant operations: _____

_____

Medications: _____ For: _____

Diabetic ( ) Allergies ( ) Fainting ( ) Epileptic ( )

Frequency of seizures: _____ Date of last seizure: _____

Heart Problem ( ) Bladder Problems ( ) Sight Problems ( ) Specify: _____
If Blind, classification, e.g. B1, B2.

_____

Hearing Problems ( ) Specify: _____

Any Behaviour Problems (i.e. biting or hair pulling) ( ) Specify: _____

Tone in upper extremities: _____
Tone in Lower extremities: _____
Tone in Trunk: _____

Spasticity ( ) Specify: _____

Balance sitting: Independent ( ) or Needs assistance ( )
Standing: _____ Walking: _____

Ambulatory: Yes ( ) No ( ) If no, explain(e.g. wheelchair, walker, braces, crutches, etc.)

_____

Co-ordination: Normal ( ) Specific Deficit: _____

Language:	Ability to Understand	Good ( )	Fair ( )	Poor ( )
	Sign Language	Yes ( )	No ( )	
	Verbal Skills	Good ( )	Fair ( )	Poor ( )

To the Medical Doctor:
Are there any exercises that you would recommend for the rider while riding? Please describe.

_____

Are there any exercises this rider SHOULD NOT be doing? Please describe.

_____

ARE THERE ANY KNOWN COMMUNICABLE DISEASES?
Please specify: _____

The undersigned hereby acknowledges that _____
is medically able to participate in the Horse Riding Program offered by T.E.A.D. – Equestrian Association for the Disabled. I concur with the referral of the patient to a volunteer physiotherapist for evaluation of his/her physical abilities and/or limitations, as deemed necessary.

Name of Rider's Doctor: _____ Phone #: _____

Address: _____ City: _____ Postal Code: _____

Signed: Physician: _____

Parent/Guardian/Rider: _____ Date: _____

****For Office Use Only****

Physiotherapists Remarks: _____

_____

Approved: Yes / No Date: _____

Signed: _____ Position: _____

PLEASE ENSURE THAT THESE FORMS HAVE BEEN SIGNED AND WITNESSED IN ALL THE APPROPRIATE AREAS TO ENABLE US TO PROCESS THEM.

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RELEASE AND AUTHORIZATION FORM (Please print)
(This form **MUST** be SIGNED and WITNESSED)

In consideration of other valuable consideration and the treatment therapy and assistance that you have agreed to give me:
I, _____ on behalf of myself, my heirs, administrators, and assigns, hereby acknowledge that I am participating in the program and activities connected therewith concluded by you at my sole risk and I exonerate and release you, your agents, volunteers, employees and all who act on your behalf from all responsibility and claims for any injury that I may suffer while participating in such a program.

Dated at _____ this _____ day of _____, 20 ___

_____
Signature of Witness Signature of rider per

_____
Signature of Parent / Guardian

PHOTO RLEASE FORM – OPTIONAL

In consideration of T.E.A.D. – Equestrian Association for the Disabled continuing to provide services to the Community, I hereby:

a) Grant permission for the said association and all members of its staff to take and use still and moving photographs or film, including television pictures of _____
(Insert the word "myself" or the name of the rider)

b) Consent and authorize T.E.A.D., its advertising agents, the news media and any other persons interested in T.E.A.D. and its work, to use and reproduce the photographs, films and pictures, to circulate and publicize the same by all means including without limiting the generality of the foregoing newspapers, television media, brochures, pamphlets, instructional materials, books and clinical material.

c) Release all claims on behalf of myself, my heirs, executors, administrators and assigns which I (or said rider) may have against the said association, its affiliates, and all members of its staff for the use of any photographs taken and used as aforesaid.

Signed: _____

Relationship to rider if applicable: _____

Witness: _____

Address: _____ City: _____

Postal Code: _____ Phone: _____ Date: _____

T.E.A.D. – EQUESTRIAN ASSOCIATION FOR THE DISABLED

EMERGENCY RELEASE TREATMENT FORM (Please print)

Student's Name: _____
Parent or Guardian: _____
Address: _____
City: _____ Postal Code: _____
Phone: _____ Date: _____
Student's Date of Birth: _____
Disability: _____ Date of Onset: _____

M.D.s Name: _____
Address: _____ City: _____
Postal Code: _____ Phone: _____

Health Card Number: _____
Health Care Insurance Company Policy: _____

Person who is authorized to give temporary assistance or care in absence of parent or guardian:
Name: _____ Phone: _____
Relationship: _____ Preferred Medical Facility: _____

Describe any medical condition requiring special precautions or treatment and any medications or dosage:
None ( ) or:
Describe: _____
_____
_____

In case of medical emergency the undersigned authorizes _____ to provide any medical/surgical and/or hospitalization for the student, including anaesthetics, which they determine necessary or advisable, pending receipt of specific consent from the undersigned.

No student can be accepted for riding instruction until this form has been completed by the parent or guardian. If the student is of legal age (18), he or she may complete this form, if he or she is legally competent to do so. Riding instruction will be under strict supervision and, although every effort will be made to avoid any accident, NO LIABILITY can be accepted by any of the organizations concerned, including T.E.A.D. – Equestrian Association for the Disabled.

Yes, I would like _____ to have riding instruction and I have discussed this with the student's doctor. I understand that NO LIABILITY can be accepted by any organization concerned with this instruction, including T.E.A.D. – Equestrian Association for the Disabled, in the event of any accident which may occur.

Signature of Parent or Guardian: _____ Date: _____

T.E.A.D. – EQUESTRIAN ASSOCIATION FOR THE DISABLED

ATLANTOAXIAL DISLOCATION EXAMINATION (Please print)

Date: _____

This is to certify that _____ who has Down Syndrome, has had the requested X-rays taken (full extension and flexion of the neck) to determine a pathological displacement of C1 or C2.

Date of X-ray: _____

Results: Positive: _____

Negative: _____

M.D.s Name (please print): _____

Address: _____

City: _____ Postal Code: _____

Telephone: _____

M.D.s Signature: _____

Medical Doctor's stamp:

NOTE: Due to the nature of this activity, persons diagnosed with Down Syndrome cannot be accepted for riding instruction without proof of a negative diagnostic X-ray for atlanto-axial instability. This form MUST BE accompanied by a signed and dated statement from a qualified medical doctor giving the date and result of the diagnostic X-ray. This form MUST BE updated every 2 years. Please attach a copy of the X-ray results.

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RIDERS PRONE TO SEIZURES RELEASE FORM (Please print)

The undersigned hereby gives consent for _____ (thereafter referred to as the client) to participate in the horse riding program offered by T.E.A.D. It is understood that there is a risk of injury because the client is prone to seizures. The undersigned hereby releases and discharges T.E.A.D. – Equestrian Association for the Disabled and its organizers, instructors, agents, volunteers, as well as the owners of any property where the program activities are carried out, from any and all claims, demands or actions inclusive of costs that may arise out of the client's participation in the program, including any claims or actions for injuries sustained by the client while participating in the program, regardless of how such injuries may be caused.

Date: _____
Next of Kin: _____
Legal Guardian: _____
Self: _____
Address: _____
City: _____
Postal Code: _____
Witness: _____

This form MUST BE completed by any rider who has had, or is prone to seizures.

CHECK LIST

__ All forms must be signed and witnessed
__ The rider's Medical Doctor must have seen and signed these forms
__ Height and weight must be filled in accurately
__ If rider is prone to, or has ever had a seizure, the seizure release form must be signed
__ If the rider has Down Syndrome, the Atlantoaxial form must be signed and proof of a negative X-ray provided
__ Emergency release treatment form must be completed with the name inserted of who you authorize to provide medical assistance if necessary