Crawford County WI Adaptive Horse Division

This form is to be used by participants in the Adaptive Horse Division of Crawford County 4-H only.

*Required

*Name: _____ *Date of Birth _____

*Phone_____ Email_____

*Street_____ *City_____ *Zip_____

Parent/Guardian _____ Phone _____

Adaptive Riding Program Attending: _____

Ride Style: ☐Western ☐English ☐Dressage ☐Bareback Pads

Reins: _____ Saddle: _____ Horse(s): _____

Mounting: ☐Block ☐Ramp ☐Ground

Dismounting: ☐Block ☐Ramp ☐Ground

Aids Required				**Rider Ability**
Arena Spotter	☐At walk	☐At trot		☐Ride at a walk
Leader (unclipped)	☐At walk	☐At trot		☐Ride at a sitting trot
Leader (Clipped)	☐At walk	☐At trot		☐Ride at a rising trot
1 Side-walker	☐At walk	☐At trot		
2 Side-walkers	☐At walk	☐At trot		How long have you been riding: _____

Please note any additional class requirements and names of aids as you require:

_____

Horse

Name: _____ Breed: _____ Age/DOB: _____

Color: _____ Height: _____ Is this horse being used by other riders: Y N

Classes you wish to enter

☐ Adaptive Showmanship - Tier 1 (beginner)
☐ Adaptive Showmanship - Tier 2 (intermediate)
☐ Adaptive Showmanship - Tier 3 (advance and being mainstreamed into a regular 4-H)
☐ Adaptive Walk Equitation - Tier 1 (beginner)
☐ Adaptive Walk/Trot Equitation - Tier 2 (intermediate)
☐ Adaptive Walk/Trot Equitation - Tier 3 (advance and being mainstreamed into a regular 4-H)
☐ Adaptive Trial - Tier 1 (beginner)
☐ Adaptive Trial - Tier 2 (intermediate)
☐ Adaptive Trial - Tier 3 (advance and being mainstreamed into a regular 4-H)

REGISTRATION AND RELEASE FORM

REGISTRATION

Participant: _____ Date of Birth: _____ Age: _____

Street: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____ Work: _____ Emergency: _____

Parents or Guardian: _____

Address/Phone: _____

School or institution presently attending: _____

In case of emergency contact: _____ Phone: _____

or contact: _____ Phone: _____

LIABILITY RELEASE

_____ (Clients Name) would like to participate in the _____ 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 bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against _____ it's Board of Directors, 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 in _____.

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

ACKNOWLEDGEMENT OF RULES AND RESPONSIBILITY

I have read and agree to abide by rules as stated in current PA 4-H Horse Show Rule Book and any additional supplement(s) that may be available. I have consulted my child's health care professional(s) and determined there are no contraindications for participation of my child in 4-H horse activities.

Date: _____ Signature _____
Client, Parent or Guardian

PHOTO RELEASE: OPTIONAL

I hereby consent to and authorize the use and reproduction by _____ of any and all photographs and any other audiovisual materials taken of me/ my son/ my daughter/my ward for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.

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

This form is to be used by participants in the therapeutic riding division only. Information contained herein will be maintained in confidence and is required for the safety and continued development of the therapeutic riding programs.

Client Medical History/Physician's Statement

Information contained herein will be maintained in confidence and is required for the safety and continued development of the Adaptive Horse Program of Crawford County.

Dear Healthcare Provider,

Your patient, _____, is interested in participating in supervised equine activities. In order to safely provide this service, our center requires that you complete the attached 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.

Thank you so much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact our office.

Riders with Atlanto-Axial Instability will need a signed statement from their doctor to participate as risk of injury at a horse show is greater.

Please indicate any medical problems not indicated above.

_____

Please indicate special precautions:

_____

Mobility Status

Ambulatory? Yes _____ No_____ If No, describe: _____

Prosthetics/Orthodontics:

Type: _____ Purpose: _____

Type: _____ Purpose: _____

Please describe any other additional information that might help us to work with this student. Thank you for your time!

Horseback riding is an appropriate activity for the above names person.

Physician's Signature: _____ Date: _____

Physician's Name (Please Print): _____

Physician's Address: _____

Phone: _____

Medical Professional:

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone :(_____) _____ License/UPIN Number: _____

Participant, Parent, or Legal Guardian: To the best of my knowledge the medical history is true and accurate.

Signature: _____ Date: _____

Client Medical History/Physician's Statement

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	Yes	No	If Yes, or History of, Describe
Auditory Impairment			
Learning Disability			
Mental Imapirment			
Psychological Impairment			
Speech Impairment			
Visual Impairment			Glasses or Contacts
Allergies			
Cardiac			
Circulatory			
Coxarthosis			
PVD			
Postural Hyptension			
Hemophilia			
Pulmonary			
Asthma/COPD			
Neurological			
Seizures			
Controlled			Type:
Last Seizure: ___/___/___			
Hydrocephalus			
Shunt			# Revisions
Sensory Loss			
Pain			
Muscular			
Contractures			
Skeletal			
Spinal Column Injury			
Subluxing Joints			
Dislocating Joints			
Laminectomy/Fusion			
Scoliosis-Degree/Type/Brace/ Last x-Ray			
Kyphosis/Lordosis – Degree/Type			
Spondylolisthesis			
Spinal Abnormality			
Osteoporosis			
Heterotrophis Ossification			
Joint Disease			
Cranial Defects			
Fractures			Location? Healed?
Other: please describe			