

Mailing Address:
701 East Third Street
Prophetstown, IL 61277



OFFICE USE ONLY	
Rte: ___ Brn. ___ Mas.	
Ent: ___ Cmp.	
S: _____	
D: _____	
T: _____ Pymnt: _____	
Frms: ___ MedHx ___ ROL	
___ MedTx ___ Pymnt.	

WHITE OAKS THERAPEUTIC EQUESTRIAN CENTER NEW STUDENT REGISTRATION PACKET

Rider's Name: _____ Phone: _____

Age: _____ DOB: _____ Gender: _____ M _____ F

Street: _____

City: _____ State: _____ Zip: _____

County: _____ Email: _____ Cell #: _____

Employer (if applicable): _____

School (if applicable): _____ City: _____

Parent/Legal Guardian's name: _____

Street: _____

City: _____ State: _____ Zip: _____

Workplace: _____ Work ph: _____

Caregiver name: _____ Phone: _____

(If applicable of dependent adult)

- ▶ Please check the area in which you wish to participate:

Therapeutic Riding: _____ Therapeutic Cart Driving: _____ Pet Therapy: _____

- ▶ Please check all sessions you wish to ride in:

Spring: _____ Summer: _____ Fall: _____

- ▶ Please list your first, second, and third choices for class day/time*:

Tuesday, Wednesday, Thursday

Morning: Class 1 - 9:00-10:00 a.m. Afternoon: Class 1 - 1:00-2:00 p.m. Evening: Class 1 - 4:00-5:00 p.m.
Class 2 - 10:30-11:30 a.m. Class 2 - 2:30-3:30 p.m. Class 2 - 5:30-6:30 p.m.

1st _____ 2nd _____ 3rd _____

*please note if you need another day/time. other days/times can be arranged for participant convenience.

Would student be interested incompeting in Special Olympics? _____ Yes _____ No

.....competing in other Horse Shows? _____ Yes _____ No

.....participating in a "Fun Show"? _____ Yes _____ No

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

Physical Function (i.e. Mobility skills such as transfer, walking, wheelchair use) _____

Psycho/Social Function: (i.e. work/school including grade completed, leisure interests, companion animals, fears/concerns, etc.)

Goals for programs (i.e. Why are you applying for participation? What would you like to accomplish?) :

Photo Release:

I do _____

I do not _____

Consent to and authorize the use and reproduction by White Oaks Therapeutic Equestrian Center of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____
(Student, Parent or Legal Guardian signature)

Proof of guardianship - I.D. must be available upon registration

WHITE OAKS THERAPEUTIC EQUESTRIAN CENTER

RELEASE OF LIABILITY

"Warning under the Equine Activity Act, adopted by the State of Illinois each participant who engages in an equine activity expressly assumes the risks of engaging in and legal responsibility for injury, loss or damage to person or property resulting from the risk of equine activities."

I, Name: _____

(staff member, rider/guardian, volunteer, or bystander)

Address: _____

Phone #: _____

DOB: _____

would like to participate in White Oaks Therapeutic Equestrian Center's equine assisted activities mounted and unmounted activities including the horse and cart-driving program.

I acknowledge that persons engaged in this program as a staff member, rider, volunteer or bystander is assuming certain inherent risks and dangers. Risks of engaging in equine activities means those dangers of conditions that are integral part of equine activities, including, but not limited to:

Risks of engaging in equine activities:

1. **The propensity of an equine to behave in ways that may result in injury, harm, or death to persons on or around them.**
2. **The unpredictability of an equine's reaction to sounds, sudden movement, and unfamiliar objects, persons, and other animals or other things.**
3. **Certain hazards such as surface and subsurface conditions.**
4. **Collisions with other equines or objects.**
5. **The potential of a participant to act in a negligent manner that may contribute to injury to the participant or others, such as failing to maintain control over the animal or not acting within his or her ability.**
6. **It is recognized that equine activities are hazardous to participants, regardless of all feasible safety measures that can be taken.**

Exceptions

1. **If Center commits an act or omission that constitutes willful or wanton disregard for the safety of the participant, and that act or omission caused the injury.**
2. **Intentionally injures that participant.**
3. **Provided the equipment or tack, and knew or should have known that the equipment or tack was faulty, and the equipment or tack was faulty to the extent that it caused the injury.**
4. **Provided the equine and failed to make reasonable and prudent efforts to determine the ability of the participant to engage safely in the equine activity and determine the ability of the participant to manage safely the particular equine based on the participant's representations of his or her ability.**
5. **Own, leases, rents, or otherwise is in lawful possession and control of the land or facilities upon which the participant sustained injuries because of a dangerous latent condition that was known to the equine activity sponsor, equine professional, or person and for which warning signs were not conspicuously posted.**

Participant, parent or legal guardian, staff member, volunteer or bystander having read and understood the above description of liability of equine activities, participants shall agree to hold harmless and release White Oaks Therapeutic Center, its staff, volunteers, committees, board member or Whiteside County Central Agricultural Society from any and all claims and damages which may occur from participating in any and all activities sanctioned by center.

Date: _____ Consent Signature: _____

This release shall remain valid until expressly revoked by the participant or, if a minor, the parent or guardian.

WHITE OAKS THERAPEUTIC EQUESTRIAN CENTER

MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

****MUST BE COMPLETED AND RETURNED PRIOR TO BEGINNING RIDING LESSONS****

Name: _____ Age: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Diagnosis: _____ Date of Onset: _____

Sex: M F Height: _____ Weight: _____ P: _____ BIP: _____

For Persons with Downs Syndrome:

AtlantoDens Interval X-Rays date: _____ Result + - X-ray date: _____

Neurological Symptoms of Atlanto Axial Instability: _____

Tetanus Shot: Yes No Date: _____

Medications: _____

Medications that are Photosensitive: _____

Please indicate if the client has a history of the following problems by checking yes or no. If yes, please include complete information pertaining to the problem.

Problem	Yes	No	Description/Comment
Auditory Impairment			
Learning Disability			
Mental Impairment			
Psychological/Emotional Impairment			(IQ if pertinent)
Speech Impairment			
Visual Impairment			Glasses:
Allergies			
Cardiac			
Circulatory:			
PVD			
Hypertension			
Postural Hypotension			
Hemophilia			
Pulmonary:			
Asthma			
COPD			
Neurological:			
Seizures			Type: Last Seizure:
Controlled			
Hydrocephalus			
Shunt			Date of last revision:
Spina Bifida			Level of defect:

Muscular:			
Contractures			
Skeletal:			
Spinal Column Injury			(if yes, describe/level)
Spinal Fusion			
Scoliosis Degree/Type			Brace/Last X-ray
Kyphosis/Lordosis			Degree/Type
Spondylolisthesis			
Spinal Abnormality			
Osteoporosis			
Joint Disease			
Cranial Defects			
Pathologic Fractures			
Fractures			Location: Healed:
Other:			
Immunity			
Pain			
Tactile Sensation			
If Spinal Cord Involvement:			Vertebral Level:
Incontinent			
Catheter: Foley/Intermittent			
Other:			

Medical History Past/Prospective

Please indicate any medical problems not indicated above, including past and prospective surgeries:

Please indicate any special precautions/needs: _____

Mobility

Independent Ambulation: Yes No Assisted Ambulation: Yes No

Aides: Crutches Braces Wheelchair

To my knowledge, there is no reason why this person cannot participate in supervised equine activities (Therapeutic riding, recreational riding, animal related activities, and horse and/or horse and carriage driving). However, I understand that the therapeutic riding center will weigh the above medical information against existing precautions and contradictions.

Physician Signature: _____ Date: _____

Physician Name: _____

Address: _____ Phone: _____

WHITE OAKS THERAPEUTIC EQUESTRIAN CENTER

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Name: _____ DOB: _____

Address: _____

Phone: _____

Physician: _____

Phone: _____

Preferred Medical Facility/Hospital: _____

Health Insurance Company: _____

Policy: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Consent Plan

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 White Oaks Therapeutic Equestrian Center and/or special events, I authorize White Oaks Therapeutic Center to:

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

This authorization includes x-rays, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: _____ Signature: _____

Participant (Parent or Legal Guardian)

OR

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 of while being on the property of White Oaks Therapeutic Equestrian Center and/or Special events. Parents or legal guardian will remain on site at all times during equine assisted activities. In the event emergency treatment/aid is required, I wish the following procedure to take place:

Date: _____ Consent Signature: _____

Participant (Parent or Legal Guardian)