Winslow
THERAPEUTIC RIDING CENTER
"Healing with Horses"
Since 1974

PREMIER ACCREDITED CENTER
PATH

2017 WINSLOW THERAPEUTIC CENTER
PARTICIPANT'S APPLICATION AND HEALTH HISTORY

(This information must be updated annually)

PARTICIPANT NAME_____ DATE_____

DOB_____ AGE_____ HEIGHT_____ WEIGHT_____ GENDER_____ETHNICITY_____

ADDRESS_____

EMAIL_____ HOME PHONE_____ CELL_____

Here at Winslow we strive to provide the safest conditions as well as a state of the art facility. In order to maintain our excellence, we ask that all participants and or their families adhere to our policies. Please review the following policies for Winslow Therapeutic Riding Center below. Failure to commit to these policies will result in loss of riding and or barn time at the participant's cost. Please initial next to each policy as well as sign and date the bottom of this form.

PARTICIPANT POLICIES:

Helmets Policy: When near/on horses, participants must wear A STM-SEI-approved riding helmets. Winslow does provide these helmets to those that need them. Please note bike helmets and or ski helmets are not acceptable. ____**Initial**

Clothing Requirements: Long pants and closed-toe shoes (with heels if possible) is required. ____**Initial**

Bad Weather: Classes will only be cancelled in the event of dangerous or threatening weather. To determine cancellations you can call Winslow directly at 845-986-6686. If we have not been able to reach you in the event we need to close there will be a message on our main voicemail. ____**Initial**

Weight Limit: Rider weight limit is 225 lbs. ____**Initial**

Saftey: Winslow reserves the right at any time to refuse any participant we cannot safely accommodate. ____**Initial**

Signing below is acknowledging that you have read and understand all of our policies and procedures here at Winslow Therapeutic Riding Center.

We look forward to working with you!

Participants Name: _____

Signature: _____ Date:_____
Participant, Parent or Legal guardian

LIABILITY RELEASE_____(RIDER'S NAME) would like to participate in the Winslow Therapeutic Riding Program. I acknowledge the risks and potential for risks of horseback riding. However, I feel the possible benefits to myself/my child/my ward are greater than the risk assumed. I hereby intend to be legally bound, for myself, my heirs and assigns, executors and administrators, waive and release all claims for damages against Winslow Therapeutic Riding Unlimited, Inc. its Board of Directors, Instructors, Therapists, Aids, Volunteers, and Employees for any and all injuries and losses, I/my child/my ward may sustain while participating in the Winslow Program.

Date_____ PRINT NAME_____

CLIENT, PARENT, GUARDIAN, CAREGIVER SIGNATURE_____

TO BE COMPLETED AND SIGNED BY THE PARTICIPANT'S PHYSICIAN

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Accredited Center will weigh the medical information above against the existing precautions and contraindications.

Physician Name: _____ MD DO NP PA Other_____
Signature: _____ Date: _____
Address: _____
Phone: _____ License/UPIN number: _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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 the agency, I authorize Winslow Therapeutic Riding Unlimited, Inc. to:

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

Client/Rider's name_____ Phone:_____

Address_____

CONSENT PLAN

☐ **I CONSENT** ☐ **I DO NOT CONSENT**

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

Date_____ Consent signature_____

Print name_____ Phone:_____

Address_____

PHOTO RELEASE (optional): I HEREBY CONSENT TO AND AUTHORIZE THE USE AND REPRODUCTION BY Winslow of any and all photographs and any other materiel, educational activities, exhibitions or for any other use the benefit of the program.

☐ **DO CONSENT** ☐ **DO NOT CONSENT**

Date_____ CLIENT, PARENT, GUARDIAN, CAREGIVER SIGNATURE_____