MAGICAL MEADOWS
THERAPEUTIC
Horseback Riding Center

APPLICATION
PARTICIPANT PROFILE...

Name_____

Date of Birth_____Height_____Weight_____ _Sex_____Age_____

Allergies..._____

Medical Problems..._____

Medications..._____

School..._____

Parent Name..._____

Address..._____

City_____State_____Zip_____

Phone..._____

How did you hear about our program?_____

GOALS for participant...(ex...follow directions, build self-esteem, smile, etc...)

_____

_____

_____

_____

_____

PHOTO RELEASE...

I DO_____

I DO NOT_____

consent to and authorize the use and reproduction by The MAGICAL Meadows of any and all photographs and any other audio/visual materials taken of me/my child for promotional material, educational activities, exhibitions or for any other use of the benefit of the Riding Center.

Signature..._____Date..._____

email address_____

MAGICAL MEADOWS
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CONFIDENTIALITY
AGREEMENT/PHOTO RELEASE

PRINT Participant Name_____

PRINT Parent/Guardian Name(IF APPLICABLE)_____

ADDRESS_____

CITY_____STATE_____ ZIP CODE_____

CONFIDENTIALITY AGREEMENT

I agree to respect and observe privacy and confidentiality of the participants of the **MAGICAL MEADOWS, INC**., and not discuss or disclose any sensitive information about any person or their family.

Signed_____Date_____

Relationship to Participant_____

PHOTO RELEASE

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to the **MAGICAL MEADOWS, INC.** permission to take or have taken still and moving photographs and films, including television pictures, of my/our self-daughter-son, and consents and authorizes the **MAGICAL MEADOWS, INC.** to use and reproduce the photographs, films and pictures and to circulate and publicize the same by all means including, but not limited to, newspapers, television media, brochures, pamphlets, instructional material, books and clinical material.

With respect to the foregoing matters, no inducements or promises have been made to me/us to secure my/our signature(s) to this release other than the intention of the **MAGICAL MEADOWS, INC.** and its work.

Signed_____Date_____

Relationship to Participant_____

MAGICAL MEADOWS
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RELEASE
HOLD HARMLESS AGREEMENT

The program at the **MAGICAL MEADOWS, INC.** provides therapeutic horseback riding for children and adults with special needs. Volunteers and horses are carefully selected and trained and safety equipment is required for all riders since horseback riding is a risk exercise.

No student will be accepted for riding instruction and no volunteer accepted for service until this form has been **READ, UNDERSTOOD, COMPLETED AND SIGNED** by the parent(s) or guardian(s) of a minor, or if the student or volunteer is of legal age and sound mind, by the student or volunteer.

Although participation in the program is under strict supervision and every effort is made to avoid injury or accident, the undersigned acknowledges the inherent risks involved in riding and working around horses. This includes bodily injury from horseback riding or being in close proximity to horses. Among other risks, both horse and rider can be injured in normal use or in competition and schooling. In order to provide this valuable service, **NO LIABILITY** can be accepted by the **MAGICAL MEADOWS, INC.** or any of the organizations or persons connected with the above named facility.

IN CONSIDERATION, for the privilege of riding and/or working around horses at the **MAGICAL MEADOWS,INC.,** the undersigned, as self, or as parent(s) or guardian(s) of the undersigned minor, jointly and severally, do hereby agree to release, hold harmless and indemnify the **MAGICAL MEADOWS,INC.,** its officers, directors, trustees, agents, employees, representatives, successors and assigns, from all manner of liability, loss, costs, claims, demands and damages of every kind and nature whatsoever, including but not limited to reasonable attorneys fees, which the undersigned or said minor may now or in the future have against the **MAGICAL MEADOWS, INC.,** its officers, directors, trustees, agents, employees, representatives, successors and assigns, on account of any accident, damage, injury or illness, physical or mental condition, known or unknown, to the undersigned or said minor, or the treatment thereof, arising as a result of, or in any way connected to acts or incidents occurring at or relating to the **MAGICAL MEADOWS, INC.,** its officers, directors, trustees, agents, employees, representatives, successors or assigns, including but not limited to their negligence or gross negligence in rendering the services described above or in anyway incidental thereto.

Date_____Participant Name (Print)_____

Participant or Parent/Guardian Signature_____

Print Parent/Guardian Name (if applicable)_____

Relationship to Participant(if applicable)_____

ADDRESS_____

CITY_____STATE_____ZIP_____

CITY_____STATE_____ZIP_____

MAGICAL MEADOWS
THERAPEUTIC
Horseback Riding Center

RIDING LESSONS...

Cancellation/Make-Up Policy...
Fee Payment Policy...

CANCELLATION & MAKE-UP POLICY...

Scheduling a make-up lesson is each rider's/families responsibility. "No shows" and cancellations made within one hour of the scheduled time, may not be made up.
If you have an excused absence or if for any reason a riding lesson is canceled by The Magical Meadows do to weather conditions, your class time will be "rolled over", which will reduce your fee for the next session.

FEE PAYMENT POLICY...

Session fees are due, in full, by the first riding date of that session. This will not only keep your time slot "reserved" but it will help support our ongoing care to our therapeutic horses.

COST PER SESSION...

$120 - class of 4 students - 6 weeks(lessons)
$180 - semiPRIVATE - class of 2 students - 6 weeks(lessons)
$240 - PRIVATE - 1 student - 6 weeks(lessons)

Special payment requests/arrangements are available.

I agree/understand the above written policies.

Signed_____Date_____

Relationship to Participant_____

MAGICAL MEADOWS
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Authorization for EMERGENCY Medical Treatment

PRINT Participant Name_____ Date of Birth_____

Parent/Guardian Name(If Applicable)_____

ADDRESS_____

CITY_____STATE _____ZIP CODE_____

PHONE # (HOME) _____ (WORK)_____

IN THE EVENT I CANNOT BE REACHED:
CONTACT _____ PHONE #_____

ALTERNATE CONTACT_____PHONE #_____

PHYSICIAN'S NAME_____PHONE #_____

Preferred Medical Facility_____

HEALTH INSURANCE CO _____POLICY # _____

List all pertinent medical information (allergies to food or drugs, medications being taken, special medical conditions):

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 the agency, I authorize the **MAGICAL MEADOWS, 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.

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 listed is unable to be reached.

CONSENT SIGNATURE_____DATE_____

PRINT NAME AND RELATIONSHIP_____

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 **MAGICAL MEADOWS, INC.** In the event emergency treatment/aid is required, I wish the following procedures to take place:

NON-CONSENT SIGNATURE_____ DATE_____

PRINT NAME AND RELATIONSHIP_____

PRINT NAME AND RELATIONSHIP_____

PARTICIPANT HEALTH HISTORY...

Name_____

Diagnosis_____ Date of Onset_____

Please indicate current or past special-needs in the following areas...

Special Need	**YES/NO**		**Comment...**
Vision	Y	N	_____
Hearing	Y	N	_____
Sensation	Y	N	_____
Communication	Y	N	_____
Heart	Y	N	_____
Breathing	Y	N	_____
Digestion	Y	N	_____
Elimination	Y	N	_____
Circulation	Y	N	_____,
Emotional	Y	N	_____
Behavioral	Y	N	_____
Pain	Y	N	_____
Bone/Joint	Y	N	_____
Muscular	Y	N	_____
Thinking/Cognitive	Y	N	_____
Allergies	Y	N	_____

Signature..._____Date..._____

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PHYSICIAN statement...
MEDICAL HISTORY

Participant_____

Address_____City_____State_____Zip_____

Diagnosis_____Date of Onset_____

Past/Prospective Surgeries_____

Medications_____

Seizure Type_____Controlled Y N Date of Last Seizure_____

Shunt Present Y N Date of last revision_____

Special Precautions/Needs_____

_____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices_____

For those with Down Syndrome: AtlantoDens Interval X-rays, date_____

Neurologic Symptoms of AtlantoAxial Instability_____

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			

Muscular_____

	Y	N	Comments...
Balance			
Orthopedic			
Allergies			
Learning Disabilities			
Cognitive			

Emotional/Psychological_____

Pain_____

Other_____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that The MAGICAL Meadows Therapeutic Riding Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to The MAGICAL Meadows Therapeutic Riding Center for ongoing evaluation to determine eligibility for participation.

Name/Title_____MD DO NP PA Other_____

Signature_____Date_____

Address_____City_____State_____Zip_____

Phone_____License/π Number_____

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