



511 W29667 Summit Avenue (US HWY 18) Waukesha, WI 53188

LifeStriders

Therapeutic Riding Center

Phone: (262) 565-6124
Email: striders@lifestriders.org
www.lifestriders.org
Fax: 866.404.3105

Therapeutic Riding Form

Authorization for Emergency Medical Treatment Form

Participant Staff Volunteer

Name: _____
Date of Birth: _____ Home Phone: _____ Email: _____
Address: _____ City: _____ State: _____ Zip: _____
Physician's Name: _____
Medical Facility: _____
Health Insurance Company: _____ Policy #: _____
Current Medications: _____
Allergies to medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

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 LifeStriders 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.

Consent Plan

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(s) above is unable to be reached.

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



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Participant's Application and Health History

GENERAL INFORMATION

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ M F

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

Phone: _____ Alternative #: _____ Email: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Address (if different from above) _____

Phone: _____

Referral Source: _____

Contact Numbers: _____

How did you hear about the program? _____

HEALTH HISTORY

Please indicate current or past problems in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

What medications are you currently taking including over-the-counter medications?



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

FUNCTION (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

SOCIAL (i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc)

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

PARTICIPATION WAIVER AND RELEASE AGREEMENT

As a participant/rider at LifeStriders Therapeutic Riding Center, I acknowledge the risks and potential risks of horseback-riding. (Under the Wisconsin Equine Activity Civil Liability Act [WI Statute 895.481], 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) However, I feel that the possible benefits are greater than the risks 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 LifeStriders, Inc., its Board of Directors, Advisors, Board, Action Committee, Instructors, Therapists, Aids, Volunteers, and/or employees for any and all injuries sustained while participating in the LifeStriders Therapeutic Riding Program.

Participant's Name (please print): _____
Participants Signature: _____ Date: _____
Parent/Guardian's Signature: _____ Date: _____

Must be signed parent/guardian if volunteer is under the age of 18

PHOTO RELEASE

I DO
 DO NOT

consent to and authorize the use and reproduction by LifeStriders of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for in benefit of tie program.

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



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Participant's Consent for Release of Information

I hereby authorize:

to release information from the records of:
(participant's name)

DOB

The information is to be released to: Liz Wolff/Lori Voecks/Veronica Sosa
(LifeStriders Therapist)

For the purpose of developing a therapeutic riding/equine activity program for the above named participant. The information to be released is marked below.

- Medical History'
- Physical Therapy evaluation, assessment and program plan
- Occupational Therapy evaluation, assessment and program plan
- Speech therapy evaluation, assessment and program plan (I.E.P.)
- Classroom Individual Education Plan
- Psychosocial evaluation, assessment and program plan
- Cognitive-Behavioral Management plan
- Other _____

Consent Signature: _____ Date: _____

Please send materials to: - -

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Participant's Medical History & Physician's Statement (Must Be Signed by Pediatrician or Treating Medical Specialist)

Participant: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____
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: _____ Result + -
 Neurologic Symptoms of AtlantoAxial Instability: _____

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			



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Physician's Statement

(Must Be Signed by Physician or Treating Medical Specialist)

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementation of an effective equestrian program.

Name of Participant: _____

Name/Title: _____ MD DO NP PA Other: _____

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____

Email: _____