

Lovesome's Student Registration Form

Please fill out all requested information.

Student name: _____ Height: _____ Weight: _____

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

School/Occupation: _____ Current Grade: _____ Birthdate: _____

Is the student his or her own legal guardian? Y N If NO provide:

Name of Parent/Guardian _____

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

Occupation: _____ Employer: _____

Occupation: _____ Employer: _____

Contact Information: How can Lovesome reach you in a non-emergency; for example to discuss scheduling?

Home #: _____

Work#: _____

Cell#: _____

Pager#: _____

What number(s) do you want called in the daytime? _____

What number(s) do you want called in the early evening? _____

Email address(es): (Only give address(es) you want used)

Personal: _____ Work: _____

Student's primary diagnosis, and any other pertinent information that would aid in a successful equestrian experience:

Diagnosis: _____

What do you as a student or parent hope to gain from this equestrian experience?

**Student Release Form
Photo Release
Confidentiality Policy**

Photo Release - I consent to and authorize the use and reproduction by Lovesome Stables, Inc. 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 the benefit of Lovesome Stables, Inc.

Date _____ Signature (Student, parent or guardian) _____

Confidentiality Policy – For the effectiveness and safety of the equestrian program, I understand that information pertaining the rider’s medical condition(s) is shared with volunteers on a need-to-know basis. All information remains confidential. I support this policy

Date _____ Signature (Student, parent or guardian) _____

Consent & Waiver - WARNING Under Kentucky law, a farm animal activity sponsor, farm animal professional or other person does not have the duty to eliminate all risks of injury of participation in farm animal activities. There are inherent risks of injury that you voluntarily accept if you participate in farm animal activities.

I hereby request that the participant named above be accepted into the riding program operated by Lovesome Stables, Inc. I acknowledge that Lovesome Stables, Inc. has fully explained to me the scope of the riding program, including the potential for serious injury which can occur from riding, caring for and being around horses and farms.

Because of the potential benefits of Lovesome Stables, Inc.’s equestrian programs, I agree to waive any claim which the above named participant or anyone accompanying the participant may have against Lovesome Stables, Inc., its employees and volunteers, Gatewood Arena, Inc., and arena owners, Paula and Duane Gatewood, and to release them from any liability or responsibility for accident, damage, injury, or illness caused to the Undersigned or to any family member or guest accompanying the Undersigned on the premises, including, but not limited to, those caused by horses or physical conditions of this farm.

Date _____ Signature (Student, parent or guardian) _____

Lovesome Stables, Inc
Equitherapy Program

Lovesome's Participant's Medical History & Physician's Statement Form
Please return original, signed form - no fax or copies accepted

Participant name: _____ 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/Phychological | | | |
| Pain | | | |
| Other | | | |

In my opinion, this patient can participate in supervised equestrian activities. I understand that Lovesome Stables, Inc. will weight the medical information above against the existing precautions and contraindications of therapeutic horseback riding. 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.

Physician's Signature: _____ Date: _____

Physician's Name (please print or stamp) _____

Address/City/Zip: _____

Lovesome Authorization for Emergency Medical Treatment Form

Please fill out all requested information.

Student name: _____ DOB: _____

In case of emergency, please contact:

| Name/Relationship | Day Phone | Evening Phone | Other Phone/Pager |
|-------------------|-----------|---------------|-------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

In the event of an emergency and the emergency contact(s) cannot be reached, please initial one of the following plans and complete the information:

_____ **Consent Plan**

In the event of an emergency and the emergency contact(s) cannot be reached, I authorize Lovesome Stables, Inc. to make health care decisions with respect to the student named.

Date: _____ Signature(student, parent or guardian): _____

Physician's name: _____ Phone: _____

Preferred Medical Facility: _____

_____ **NON-Consent Plan - I do NOT consent to Lovesome Stables, Inc. making healthcare decisions concerning the student**

If the undersigned does NOT desire to grant Lovesome Stables, Inc. authority to make health care decisions for the student if the undersigned is not available, please initial the line before "NON-CONSENT PLAN" and state below the procedures to be followed if the student becomes ill or is involved in an accident:

Date: _____ Signature(student, parent or guardian): _____

Print Name: _____

Day Phone _____ Evening Phone _____ Other Phone/Pager _____

Address: _____

Please return this completed form by: Fax/Email/Mail