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/her own legal guardian? Y N If NO, please provide the following information:

Name of parent(s)/guardian(s): _____

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

Occupation: _____ Employer: _____

Occupation: _____ Employer: _____

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

Home #: _____

Cell #: _____

Work #: _____

Email address(es): Please only list email addresses that you want to be used.

Personal: _____ Work: _____

Please describe the student's primary diagnosis: _____

Are there any specific strategies that could be used to enhance this student's equestrian experience?

_____

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

_____

Signature: _____ Date: _____

MEDICAL INFORMATION FORM

Participant's name: _____ DOB: _____ Height: _____ Weight: _____

Diagnosis: _____ Date of Onset: _____

Past/Upcoming Surgeries: _____

Medications: _____

Seizure Activity: Y N Seizure Type: _____ Date of last seizure: _____

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs: _____

Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N Braces: _____

For those with Down Syndrome: AtlantoDens Interval X-rays, Date: _____ Result: + -

Neurologic Symptoms of AtlantoAxial Instability: _____

Please indicate present 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			

In my opinion, this patient can participate in supervised equestrian activities. I understand that Lovesome Stables, inc. will weigh the medical information provided 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:_____

Authorization for Emergency Medical Treatment Form

Please fill out all requested information.

Student Name: _____ DOB: _____

In case of emergency, please contact:

Name/Relationship Home Phone Cell Phone Work Phone

_____
_____
_____

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 requested:

_____ **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 above.

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 health care decisions with respect to the student named above. If the Undersigned does **not** desire to grant Lovesome Stables, Inc. authority to make health care decisions for the student and if the Undersigned is not available, please state the procedures to be followed if the student is in need of medical attention due to illness or accident:

_____

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

Print Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

PHOTO RELEASE, CONFIDENTIALITY POLICY &

STUDENT RELEASE FORM

Name of Student: _____

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 this student for promotional material, educational activities, and exhibits 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 to the student's medical condition(s) is shared with volunteers on a need-to-know basis. All information remains confidential. I agree with and 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, volunteers, and Board members 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): _____

ALLERGY INFORMATION & TREATMENT

Student Name:_____ Date:_____

Please check one:

_____ No known allergies _____ Has known allergies

If there are known allergies, please complete the following section for each type of allergy. Please note below if an epipen is needed and its location.

Allergic to: _____

Reaction: _____

Treatment:_____

Call 911 if: _____

Allergic to: _____

Reaction: _____

Treatment: _____

Call 911 if: _____

Allergic to: _____

Reaction: _____

Treatment: _____

Call 911 if: _____

Please note location of **epipen** during lessons - _____

Form completed by:_____ Relationship:_____

242 Boltz Lake Rd. Dry Ridge, KY 41035 859-653-7410 Fax 859-919-0118