

**LIABILITY RELEASE**

That I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or that I, the undersigned parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor, for and in sole consideration of the privilege of permitting said person to participate in activities at or sponsored by REACH Therapeutic Riding Center (RTRC) and recognizing that horseback riding activities involve certain inherent dangers and risks to persons and property, do hereby agree to assume for myself and on behalf of my ward or child, the risks and dangers attendant to such activity, including but not limited to: falling or being thrown from a horse, being kicked, stepped on or bitten by a horse or other animal, and/or injuries sustained while riding, mounting or dismounting a horse. I further acknowledge the risks and potential for risks associated with recreational and outdoor activities, including but not limited to: snake, animal or insect bites; uneven ground; sun, cold and wind exposure; cuts and scrapes; sore or pulled muscles; broken, dislocated or fractured bones; nerve damage; internal injuries; head injuries; grievous bodily injury or death. However, I feel that the possible benefits to myself, child or ward are greater than the risk assumed.

I hereby, intending to be legally bound, for myself and my child or ward, heirs and assigns, executors or administrator, waive and forever release, acquit, discharge and hold harmless all claims for damages against RTRC, its board of directors, trustees, agents, instructors, therapists, employees, representatives, volunteers, owners of property on which RTRC operates, successors or assigns on account of any personal injuries and/or personal damages known or unknown, or in anyway growing out of, the acts of RTRC, its board of directors, trustees, agents, instructors, therapists, aids, employees, representatives, volunteers, owners of property on which RTRC operates, successors or assigns.

**WARNING**

**I understand that under Texas Equine Liability Act (Chapter 87, Civil Practice and Remedies Code),**

**an equine professional is not liable for an injury to or the death of a participant in equine activities**

**resulting from the inherent risks of equine activities.**

I, the undersigned, have read this waiver of liability in its entirety. I understand the terms of this release and have signed this release voluntarily and with full knowledge of the effects thereof.

Participant Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(If participant is under18 years of age)*



**PHYSICIAN ASSESSMENT & PERMISSION**

**~~To be completed by physician~~**

Client’s Name: Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_

 Diagnosis:

Primary: Date of Onset: \_\_\_\_\_\_\_\_\_\_

Secondary: Date of Onset: \_\_\_\_\_\_\_\_\_\_

Other: Date of Onset: \_\_\_\_\_\_\_\_\_\_

Past/Prospective Surgeries

Medications

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seizures: \_\_\_\_\_No \_\_\_\_\_Yes Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last seizure: \_\_\_\_\_\_\_\_\_

Shunts, Implants:

Mobility: Independent Ambulation: \_\_\_\_ Yes \_\_\_\_\_No Assisting Devices:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***In order to safely provide this service, REACH requests that you please note that the following conditions may suggest precautions and contraindications to equestrian activities. Therefore, when completing this form, please indicate whether these conditions are present, and to what degree.***

**Orthopedic**

Atlantoaxial Instability - include neurologic symptoms

Coxa Arthrosis

Cranial Deficits

Heterotopic Ossification/Myositis Ossificans

Joint subluxation/dislocation

Osteoporosis

Pathologic Fractures

Spinal Joint Fusion/Fixation

Spinal Joint Instability/Abnormalities

**Neurologic**

Hydrocephalus/Shunt

Seizures

Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

**Other**

Indwelling Catheters/Medical Equipment

Medications - i.e. photosensitivity

Poor Endurance

Skin Breakdown

**Medical/Psychological**

Allergies

Animal Abuse

Cardiac Condition

Physical/Sexual/Emotional Abuse

Blood Pressure Control

Dangerous to self or others

Exacerbations of medical conditions (i.e. RA, MS)

Fire Settings

Hemophilia

Medical Instability

Migraines

PVD

Respiratory Compromise

Recent Surgeries

Substance Abuse

Thought Control Disorders

Weight Control Disorder

Client’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***As thoroughly as possible, please indicate current or past difficulties/symptoms in the following systems/areas that apply including surgeries.***

|  |  |  |  |
| --- | --- | --- | --- |
| **Area** | **No** | **Yes** |  **Degree/ Comments** |
| Auditory |  |  |  |
| Visual |  |  |  |
| Speech |  |  |  |
| Tactile/Sensory |  |  |  |
| Cardiac |  |  |  |
| Circulatory |  |  |  |
| Pulmonary |  |  |  |
| Integumentary/Skin |  |  |  |
| Immunity |  |  |  |
| Neurologic |  |  |  |
| Muscular |  |  |  |
| Orthopedic |  |  |  |
| Bowel/Bladder |  |  |  |
| Learning Disabilities |  |  |  |
| Cognitive |  |  |  |
| Emotional/Psychological |  |  |  |
| Behavior |  |  |  |
| Other |  |  |  |
|  |  |  |  |

|  |
| --- |
| **For those with Down Syndrome**:An Altlantoaxial x-ray and annual exam to exclude Atlantoaxial instability is required for clients with Down Syndrome over the age of 3. Date of X-Ray:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Neurologic Symptoms of Atlantoaxial instability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Given the above diagnosis and medical information, this person is not medically precluded from participation in supervised equestrian activities. I understand that REACH Therapeutic Riding Center will weigh the medical information indicated above against any existing precautions and/or contraindications before accepting this person for therapeutic horseback riding lessons. Therefore, I refer this person to REACH for ongoing evaluation to determine eligibility for participation.

Name/Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MD, DO, NP, PA Other

Signature: Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

Phone: License/UPIN Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_