



**Registration Form Filled Out On:**

**For Session:**

Client Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

**Client Phone Numbers**

Home: \_\_\_\_\_

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

Quick Information Sheet <i>(All information required)</i>		
Date of Birth: _____ / _____ / _____	Month	Day Year
Height: _____ cm/inch	Weight: _____ kg/lb	
Gender: <input type="checkbox"/> Male	<input type="checkbox"/> Female	
Disability Diagnosis: _____		
Date of Onset: _____		
AHC #: _____		
Physician's Name: _____		

Current PARDS Member? Yes  No  If yes, membership # \_\_\_\_\_

I would like to receive PARDS newsletter via e-mail.

Please provide e-mail address \_\_\_\_\_

**Living With:**

Independently

Parent(s)/Guardian(s) Names: \_\_\_\_\_

Group Home Name of Home: \_\_\_\_\_

Contact Person for Client: \_\_\_\_\_

**Contact Phone Numbers**

Home: \_\_\_\_\_

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

Public Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
(if applicable)

**Emergency Contact:** \_\_\_\_\_ **Relation to Client:** \_\_\_\_\_

**Phone Home:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Cell:** \_\_\_\_\_



**Release Form (Must be filled out by parent/legal guardian/client with legal ability to sign for self)**

**Please read the following and initial below:**

1. It is the responsibility of the client/parent/guardian to notify PARDS of any medical, contact information, or guardianship changes.
2. Clients with completed forms and a physician's release will undergo an assessment by a PARDS Instructor prior to acceptance into program.
3. For the protection and safety of all riders, clients who are under the care of a parent, guardian, or aide shall have that person present at all lessons.
4. PARDS reserves the right to remove a client from the program at any time if it is deemed unsafe for the client to continue riding.

**I have read and fully understand the above: \_\_\_\_\_ (please initial)**

**Liability Release**

\_\_\_\_\_ (client name) would like to participate in the Peace Area Riding for the Disabled Society (hereby known as PARDS) program. I acknowledge the risks and potential for risks of horseback riding and horse-related activities. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk 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 PARDS, its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees of any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in any PARDS program.

**Photo Release**

Please check one:  I hereby consent  
 I hereby do not consent

...to and authorize to the use and reproduction by PARDS of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

**Information Release**

I hereby authorize PARDS to release to its instructors and helpers such information on myself/my son/my daughter/my ward as may be necessary to conduct a beneficial and safe riding program.

**Authorization for Emergency Medical Treatment**

In the event of an emergency where medical aid/treatment is required due to illness or injury during the process of receiving services, or while on the property of the agency, I authorize PARDS to:

1. Secure and retain medical treatment and transportation of needed, and
  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 as "life saving" by the physician. This provision will only be invoked if the parent/guardian/emergency contact listed above is unable to be reached.

**I hereby am signing for the Liability Release, Photo Release, and Information Release, as well as the Authorization for Emergency Medical Treatment.**

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(please print)

**Witness Name:** \_\_\_\_\_ **Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(please print)



**Client Information Sheet (To be filled out by Client, parent/guardian, or aide)**

It is important that this form be filled out in detail to assist PARDS in developing a suitable riding program and set goals for the client.

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Name of Person filling out this form: \_\_\_\_\_ Filled out on: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Disability/Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Ability to Understand:  Good  Fair  Poor

Please Comment: \_\_\_\_\_

Speech:  Good  Fair  Poor

Please Comment: \_\_\_\_\_

Language:  English  Sign  Other \_\_\_\_\_

Sensory Function (please indicate good, fair, or poor and comment if necessary)

Sight: \_\_\_\_\_

Hearing: \_\_\_\_\_

Tactile: \_\_\_\_\_

Behaviors and/or fears:  Yes  No If Yes, please explain: \_\_\_\_\_

Continence Issues:  Yes  No If yes, please explain: \_\_\_\_\_

Balance (Please indicate good, fair, or poor and comment if necessary)

Sitting: \_\_\_\_\_

Standing: \_\_\_\_\_

Walking: \_\_\_\_\_

Muscle Tone (spasticity, flaccidity, etc)

Upper extremities: \_\_\_\_\_

Lower extremities: \_\_\_\_\_

Tone in trunk: \_\_\_\_\_

What are the client's goals in our program?

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



**Medical History & Physician Release Form (to be filled out by client's physician only)**

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Primary Disability/Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Secondary Disability/Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

**\*\*For Persons with Down Syndrome\*\***

Cervical X-ray for Atlantoaxial Instability:  Positive  Negative Date of X-Ray: \_\_\_\_\_

**Epileptic:**  Yes  No Seizure Type: \_\_\_\_\_ Frequency: \_\_\_\_\_ Controlled:  Yes  No  
 Date of Last Seizure: \_\_\_\_\_

**Diabetic:**  Yes  No Insulin: \_\_\_\_\_

**Communicable Disease:**  Yes  No If yes, specify: \_\_\_\_\_

**Mobility:** Independent:  Yes  No Crutches:  Yes  No Wheelchair:  Yes  No

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment, using back of form if necessary.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Circulatory			

Indicate any appliances (Harrington's rod, etc.): \_\_\_\_\_

Special Precautions: \_\_\_\_\_

*In my opinion, this patient can participate in supervised equestrian activities. In conjunction with these activities I concur in the referral of the patient to a physical/occupational therapist or other health care professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program.*

Physician Name/Stamp: \_\_\_\_\_ Physician Signature: \_\_\_\_\_

(please print)

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_