Stirrups 'n Strides
Therapeutic Riding Center, Inc.

Betty Gray, Director
352-427-3569
4246 W. Hwy 318
Citra, FL 32113

Rider/Driver Application and Health History

PLEASE PRINT **DATE:** _____

PARTICIPANT'S NAME: _____ **(M/F)** ____ **Age:** ____

Date of Birth: _____**(month)** _____**(day)** _____ **(year) - Weight:** _____ **Height:** _____

(Please circle relationship (M)other) or (F)ather) (Self) regarding cell phones and work phone)

PARENT(S), GUARDIAN, RIDER OR CONTACT PERSON:_____
Address: _____ **City:** _____ **State:** _____ **Zip:**_____
Phones: Home: _____**Cell:** _____ **(m/f/self) Cell:** _____ **(m/f/self)**
Work: _____ **(m/f) Work:** _____ **(m/f) Contact person:** _____

E-MAIL ADDRESS: _____

EMERGENCY CONTACT: authorized to give temporary assistance or care in absence of parent /guardian:

Name: _____ **Relationship:** _____
Phone: Home: _____ **Work:** _____ **Cell:** _____

Participant: Ethnic/Race: ☐White ☐Hispanic ☐Black/African American ☐Asian ☐Other

Participant's Disability: _____
Date of onset: _____
Physician's Name: _____
Physician's Address: _____ **Phone#:** _____
Health Care Insurance Co: _____ **Policy #:**_____

HEALTH HISTORY - ***Please indicate current or past problems in the following areas:***

	Yes	No	Describe
Vision			
Hearing			
Sensation			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Pain			
Joint/Bone			
Muscular			
Allergies			
Thinking/Cognition			
Communication			
Emotional			
Behavioral			

MEDICATIONS ***Please list all medications you are currently taking, including over the counter medications. Please indicate dosage and frequency.***

_____
_____
_____
_____
_____

FUNCTION ***Please describe limitations of your abilities or difficulties which will require assistance or special equipment. (Example: Mobility skills such as walking, transfers, wheelchair use, driving or bus riding).***

_____
_____
_____
_____

Describe any medical conditions requiring special precautions or treatment:

(A) None_____

(B) Please describe _____
_____
_____
_____
_____
_____

PHOTOGRAPH RELEASE

I ☐ DO ☐ DO NOT consent to and authorize the use and reproduction by Stirrups 'n Strides of any and all photographs and any other audio/visual materials of_____ (please print name), Me / my son / my daughter / my ward (please circle), by Stirrups 'N Strides Therapeutic Riding Center, Inc. for purposes of promotional or educational materials or activities, or for any other use for the benefit of Stirrups 'N Strides Therapeutic Riding Center, Inc.

Name (please print): _____

Client Signature (if age 18 and legally competent) _____

Date: _____

Parent/Guardian Signature _____

Date: _____

A.PERMISSION TO PARTICIPATE **Date:_____**

No rider or driver can be accepted for riding or driving instruction until this form has been completed by the Parent/Parents and/or Guardian/Guardians. If the rider or driver is of legal age (18), he or she may complete this form, if he or she is legally competent to do so. Riding/driving instruction is conducted under strict supervision and all reasonable efforts are made to ensure the safety of riders/drivers. **NO LIABILITY** can be accepted by any of the organization concerned, including but not limited to Stirrups 'n Strides Therapeutic Riding Center, Inc., and any of the associated staff or volunteers.

I, _____, permit _____ to participate in the Stirrups 'N Strides Therapeutic Riding Center, Inc., riding and/or driving program. I certify that I have discussed participation in this program with my / his / her *(please circle)* medical practitioner.

B. MEDICAL EMERGENCY CONSENT **Date: _____**

In case of a **Medical Emergency**, I _____, authorize **Stirrups 'n Strides Therapeutic Riding Center, Inc.** to provide such medical assistance as they determine to be necessary. In the event that the participant's physician cannot be reached, the undersigned authorizes any medical care, surgical care, and/or hospitalization for the participant, including anesthetic, which is determined necessary or advisable, pending receipt of a specific consent from the undersigned.

C. LIABILITY RELEASE AGREEMENT **WARNING – Under Florida law, Statute #773.01-773.05, an equine activity sponsor or equine sponsor or equine professional is not liable for any injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.**

I, _____, acknowledge the risks and potential for risks of horseback riding/driving. I believe the possible benefits to myself / my son / my daughter / my ward *(please circle)* 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 Stirrups 'N Strides Therapeutic Riding Center, Inc., its Board of Directors, personnel, volunteers, for any and all injuries and/or losses I / my son / my daughter / my ward *(please circle)* may sustain while participating in riding and/or driving at Stirrups 'N Strides Therapeutic Riding Center, Inc.

Name Client (please print): _____ **Date**: _____
Florida Driver License or Florida ID number _____

Signature (age 18 and over, legally competent) _____

Name of Parent or Guardian if underage (please print): _____
Florida Driver License or Florida ID number _____

Signature: _____

SWORN TO AND SUBSCRIBED BEFORE ME this _____ day of _____, 20____.

Notary Public _____ My Commission Expires _____