Administrative Office*11211 Katy Freeway, Suite 660*Houston, TX 77079
281-356-7588*Fax 281-888-5269
SIRE Fort Bend at RSSLC * 2100 Preston Street * Richmond, TX 77469
SIRE Hockley * 24161 Spring Dr. * Hockley, TX 77447
SIRE Spring * 4610 Sloangate * Spring, TX 77373

SIRE is a Premier Accredited Center through the Professional Association of Therapeutic Horsemanship International (PATH INTL)

REGISTRATION AND RELEASE FORM

SIRE SITE: ☐ Hockley ☐ Spring ☐ Richmond/Fort Bend

Client Information:

Name: _____

Date of Birth: _____ Sex: _____ Height/Weight: _____

Diagnosis: _____ Date of Onset: _____

Address: _____

City/State/Zip: _____

Client Occupation/Employer or School/Grade: _____

Parent/Guardian Information (If Applicable):

Father's Name: _____ Mother's Name: _____

Address (if different): _____

Father's Primary Phone (Cell, Home or Work?): _____
Circle One

Father's Alternate Phone #'s (Cell, Home or Work?): _____
Circle One

Father's E-mail Address: _____

Father's Occupation/Employer: _____

Mother's Primary Phone (Cell, Home or Work?): _____
Circle One

Mother's Alternate Phone #'s (Cell, Home or Work?): _____
Circle One

Mother's E-mail Address: _____

Mother's Occupation/Employer: _____

Alternate Contact Name & Relationship to client: _____

Alternate Phone #'s (Cell, Home or Work?): _____
Circle One

E-mail Address: _____

Guardian/Caregiver Information (If Applicable):

Name: _____

Address: _____

Primary Phone (Cell, Home or Work?): _____
Circle One

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REGISTRATION AND RELEASE FORM (Cont.)

LIABILITY RELEASE

_____(Client's Name) would like to participate in the SIRE, Inc. program. I acknowledge the risks and potential for risks of horseback riding. 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 SIRE, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my son/my daughter/ my ward may sustain while participating in SIRE, Inc.

WARNING - Under Texas law (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.

Date: _____ Signature: _____

Client, Parent, or Guardian

PHOTO RELEASE: (Please indicate your preference by signing your consent or non-consent)

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

I **consent** to use of photographs

Date: _____ Signature: _____

Client, Parent, or Guardian

I **do NOT consent** to use of photographs

Date: _____ Signature: _____

Client, Parent, or Guardian

Note: It is the policy of SIRE to protect and preserve the confidentiality of all Protected Information and SIRE will not use or disclose Protected Information without authorization unless disclosure is required by law. Protected Information includes (but is not limited to) names, mailing address, telephone numbers and email addresses.

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Annual Health History and Personal Goals

Name: _____

Do you have any conditions, which might be affected by the weather (heat, cold), the environment (insect allergies, asthma, dirt), or the animals (allergies)? _____

Please explain any recent changes in health status. _____

Please list current medications. _____

Please list your personal goals for the next semester.

Equestrian goals: _____

Functional/life skills goals: _____

Social goals: _____

Signature: _____ Date: _____

Print name and relationship: _____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

SIRE SITE: ☐ Hockley ☐ Spring ☐ Richmond/Fort Bend

Client's Name: _____ Phone: _____

Address: _____

In the event of an emergency:

contact: _____Relationship _____Phone: _____

contact: _____Relationship _____Phone: _____

contact: _____Relationship _____Phone: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Policy #: _____

Allergies, Current Meds: _____

CONSENT PLAN

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

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

CONSENT

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. This provision will **only** be invoked if the persons listed above are unable to be reached.

Date: _____ Consent Signature:_____

Client, Parent, or Guardian

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

_____

_____

Date: _____ Non-Consent Signature:_____

Client, Parent, or Guardian

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Clients' Medical History and Physician's Statement

• *Must be signed by Physician and Client/Parent/Guardian* •

Client Name: _____M/F: _____Date of Birth_____ Height _____ Weight _____

Diagnosis_____ Date of Onset_____

Seizure Type_____ Controlled_____ Date of last seizure_____

Medications_____

Shunt Present : Yes No Date of last shunt revision: _____

Past/Prospective surgeries: _____

Please indicate if patient has a problem and/or surgeries in the following areas by checking Yes or No. If yes, please comment.

Areas	Yes	No	Comments
Behavioral			
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning			
Psychological			
Other			

Mobility: Independent Ambulation ☐ Yes ☐ No, Crutches ☐ Yes ☐ No, Braces ☐ Yes ☐ No, Wheelchair ☐ Yes ☐ No

▶ Client/Parent/Guardian Signature _____ ◀ **Date** _____

*****PHYSICIAN MUST SIGN AND DATE THIS FORM BELOW *****

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that SIRE will weigh the medical information above against the existing precautions and contraindications. Therefore I refer this person to SIRE for ongoing evaluation to determine eligibility for participation. **I have read the attached Precautions and Contraindications.**

** FOR PERSONS WITH DOWN SYNDROME:
Neurologic symptoms of Atlanto Axial Instability. ☐ Present ☐ Absent

Please indicate any special precautions: _____

▶ Physician Signature _____ ◀ **Date** _____

Physician Name (please print) _____ MD, DO, NP, PA Other _____

Address _____ Phone _____

City, ST, Zip _____

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Precautions & Contraindications

Precautions and Contraindications:
The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Please review this information, and if present, contact SIRE for more information.

ORTHOPEDIC
Atlantoaxial Instability
Coxa Arthrosis
Cranial Deficits
Osteoporosis
Heterotopic Ossification/Myositis
Joint subluxation/dislocations

NEUROLOGIC
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities
Seizure Disorder
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia
Hydrocephalus/Shunt

OTHER
Indwelling Catheters
Skin Breakdown
Weight exceeds 200 pounds

MEDICAL/PSYCHOLOGICAL
Animal Abuse
Physical/Sexual/Emotional Abuse
Dangerous to self or others
Exacerbation's of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders

Possible Reasons for Client Discharge

Please be advised of the following reasons that may lead to discharge from the riding program.

- The client's inability to maintain head and neck control while riding presents a safety concern.
- The client's inability to maintain sitting balance while riding presents a safety concern.
- The client exceeds a weight that can safely be managed by staff, volunteers, and/or horses.
- Uncontrolled and/or inappropriate behavior that constitutes a safety risk to client, volunteers, staff and/or horse.
- Any change in the client's medical, physical, cognitive, or emotional condition that makes therapeutic riding unsafe for the client, staff, volunteers and/or horse.
- Three scheduled appointments are missed without prior cancelation.
- Nonpayment of fees.

GETTING TO KNOW YOU

Please fill out this page for our Rider Notebook. The Rider Notebook is for the volunteers to get to know a little about the riders they will be working with.

_____ SIRE Site: ☐ Hockley ☐ Spring ☐ Fort Bend
Date

PICTURE
(Optional)

My full name is_____

Please call me _____. My birth date is _____
(name I go by)

I began riding at SIRE on _____(date).

Family members: _____

Pets: _____

My interests or hobbies are: _____

My goals for riding therapy are: _____

(Optional) Please supply any details about the rider you think might be helpful to the volunteers who will be working with him/her/you. (Speech, Vision, Comprehension)

_____

_____

_____

_____

Particular methods that this rider responds to: _____

_____

_____