



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

## REGISTRATION AND RELEASE FORM

SIRE SITE:     Spring     Fulshear/Fort Bend

### Client Information:

Name:_____	Date of Birth:_____	Gender:_____
<b>Height:_____</b>	<b>Weight:_____</b>	Diagnosis:_____
Address:_____		City/State/Zip:_____
Phone:_____	Email:_____	
Client Occupation/Employer or School/Grade:_____		

### Person completing application other than client (parent/guardian information if applicable)

Name:_____	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Guardian
Address (if different):_____			
Cell Phone:_____	Work Phone:_____		
Email Address:_____	Occupation/Employer:_____		

### Parent/guardian information (if applicable)

Name:_____	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Guardian
Address (if different):_____			
Cell Phone:_____	Work Phone:_____		
Email Address:_____	Occupation/Employer:_____		

### Caregiver information (if applicable)

Name:_____	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Guardian
Address (if different):_____			
Cell Phone:_____	Work Phone:_____		
Email Address:_____	Occupation/Employer:_____		

### Alternate contact (if applicable)


Name:_____	Relationship to Client:_____
Cell Phone:_____	Email Address:_____

## 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., it's 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: \_\_\_\_\_  \_\_\_\_\_  
Client, Parent, or Guardian

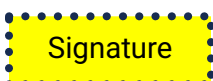
**PHOTO RELEASE:** Please indicate your preference by signing your consent *OR* non-consent

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: \_\_\_\_\_  \_\_\_\_\_  
Client, Parent, or Guardian

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

Date: \_\_\_\_\_  \_\_\_\_\_  
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 of Client: \_\_\_\_\_

**Do you have any conditions which might be affected by the weather (extreme heat or cold), the environment (insect, allergies, asthma, dirt, animals, etc.):**

**Please explain any recent changes in health status:**

**List current medications:**

**List personal goals for therapeutic horsemanship:**

- Equestrian:
  
- Functional/Life skills
  
- Social
  
- Other

**Any additional information that you'd like to share:**

Name of person completing this form & relationship to client:

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



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## AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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Client 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: \_\_\_\_\_  Closest

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

**ALLERGIES, CURRENT MEDS, ETC.:**

### **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 Xray, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the contacts listed above are unable to be reached.

Date: \_\_\_\_\_ 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. **I understand that I must be present at all times when the above client is receiving services or while on the property of the agency. If I am not present, no services will be offered for that session.**

Date: \_\_\_\_\_ Signature \_\_\_\_\_  
*Client, Parent, or Guardian*