Administrative Office*PO Box 924067*Houston, TX 77292
281-356-7588*Fax 1-866-495-1351
SIRE Fort Bend * 7206 Pool Hill Rd * Fulshear, TX 77441
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: ☐ **Spring** ☐ **Fulshear/Fort Bend**

Client Information:

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

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

Name:_____ ☐Mother ☐Father ☐Guardian
Address (if different):_____
Cell Phone:_____ Work Phone:_____
Email Address:_____ Occupation/Employer:_____

Parent/guardian information (if applicable)

Name:_____ ☐Mother ☐Father ☐Guardian
Address (if different):_____
Cell Phone:_____ Work Phone:_____
Email Address:_____ Occupation/Employer:_____

Caregiver information (if applicable)

Name:_____ ☐Mother ☐Father ☐Guardian
Address (if different):_____
Cell Phone:_____ Work Phone:_____
Email Address:_____ Occupation/Employer:_____

Alternate contact (if applicable)

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

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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., 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:_____ 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 <u>NOT</u> consent to use of photographs

Date:_____ Signature _____
Client, Parent, or Guardian

<u>Note:</u> *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

SIRE SITE: ☐ **Spring** ☐ **Fulshear/Fort Bend**

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