

**Returning Recreational Riders**  
**Registration Checklist**

Please use this checklist to ensure that all information has been completed. Participation in our program cannot occur until all information has been received. Re-registration will be much smoother if you complete all forms correctly. Incomplete forms will be returned to you. Thank you in advance for your attention and thoroughness at this time.

**Please complete the forms listed below:**

\_\_\_ **Participant's Application, Photo Release, and Health History**

- Complete all requested information. Use N/A for any line that is not applicable.
- Circle DO or DO NOT under Photo Release, sign and date.
- Sign and date on the bottom of page 3.

\_\_\_ **Participant's Authorization for Emergency Medical Treatment Form**

- Complete all requested information. Use N/A for any line that is not applicable.
- Complete Consent or Non-Consent Plan, sign and date.

**Participant's Application, Photo Release, and Health History**

**GENERAL INFORMATION:**

Participant's Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: M F  
Address Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell # /Work#: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Employer/School: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

Parent/Legal Guardian/Caregiver: \_\_\_\_\_  
Address (if different from above): \_\_\_\_\_  
Phone #: \_\_\_\_\_ Alternative #: \_\_\_\_\_

**If you are a new applicant:**

How did you hear about our program? \_\_\_\_\_  
If referred, please list source and date: \_\_\_\_\_  
If you have any previous riding/horse experience, please describe: \_\_\_\_\_  
\_\_\_\_\_

**If you currently ride at W.F.T.E., Inc.** please list start date: \_\_\_\_\_

**PHOTO RELEASE:**

**(please circle one)** I DO / DO NOT consent to and authorize the use and reproduction by Windrush Farm Therapeutic Equitation, Inc. of any and all photographs and any other audio/visual materials taken of me/my son/daughter/ward for promotional materials, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Participant (Parent or Legal Guardian)

**RIDING GOALS:** (What you would like to accomplish during your time with us.)

*Short Term* (During the next 6–12 months): \_\_\_\_\_  
\_\_\_\_\_

*Long Term* (During the next 2-3 years): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OTHER GOALS:** (This could include social, recreational, professional/career, etc.)

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

**AREAS OF FOCUS/STRENGTHS/WEAKNESSES**

*Riding a horse involves many aspects of the whole person; the physical, cognitive, and emotional. Participating in riding lessons adds even more dimensions to the scenario, such as our learning styles, spatial awareness, social interactions, etc.* Please use this section to discuss information that you believe might be helpful or issues that you would like addressed, so that the instructor can create a beneficial, supportive lesson environment for you/your child. A good place to start might be the teaching environment, aids, and tools that best supports your learning style and needs. \_\_\_\_\_

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**MISC. HEALTH ISSUES**

Please include any health issues (i.e. allergies, asthma, reactions to medications, dizziness, etc.) that you feel staff should be aware of.

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**PREFERENCES**

Although the needs and requirements of all our riders is the priority, every effort is made to accommodate the preferences of our riders. Toward that goal, please feel free to share with us your “favorites” in horses and tack. It would be beneficial if you would explain why you prefer a certain horse or piece of equipment so that, if we can not exactly meet your wishes, we can come close. \_\_\_\_\_

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**CONCERNS**

This could include any past riding experiences that caused a loss of confidence, any conditions or circumstances that you feel could interfere with your ability to ride safely or to your full potential, any fears, etc, \_\_\_\_\_

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**Lessons at Windrush are a team effort. Your instructor wants and appreciates your input throughout the riding session. Please feel free to ask questions, make suggestions, and give feedback. Discussions of any length can be done on the phone or via e-mail. Each instructor and staff member has an e-mail address for your convenience.**

**First name@windrushfarm.org**

**HEALTH HISTORY**

\*\*\*\*\* Please answer all questions below.

Please indicate current or past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

**If you have a diagnosis:**

**Diagnosis** \_\_\_\_\_ **Date of Onset** \_\_\_\_\_

**MEDICATIONS** (include prescription and over-the-counter: name, dose, and frequency):

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

**PHYSICAL FUNCTION** Describe, what you would consider, your potential difficulties when mounting/dismounting and riding a horse. \_\_\_\_\_

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

**COGNITIVE/LEARNING SKILLS** (i.e. Learning Disabilities, communication aids or tools): \_\_\_\_\_

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

**PSYCHO/SOCIAL FUNCTION** (i.e. Work/school, behavior/safety issues, relationship-family structure, support systems, fears/concerns. etc.): \_\_\_\_\_

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

To the best of my knowledge the above information is up to date and accurate.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Participant (parent or legal guardian)**

**WARNING:**

UNDER MASSACHUSETTS LAW, 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, PURSUANT TO SECTION 2D OF CHAPTER 128 OF THE GENERAL LAWS.



## Participant's Authorization for Emergency Medical Treatment Form

Participant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Family Email Address: \_\_\_\_\_

In the event of an emergency, contact;  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Physician's Name \_\_\_\_\_ Telephone \_\_\_\_\_  
Preferred Medical Facility: \_\_\_\_\_  
Health Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Current medications: \_\_\_\_\_

State any information that you want supplied to a medical professional treating you in an emergency: \_\_\_\_\_

### 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 premises operated by Windrush Farm Therapeutic Equitation, Inc., I authorize Windrush Farm Therapeutic Equitation, 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.

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 person below is unable to be reached.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_  
Participant (Parent or Guardian if participant is under the age of 18 yrs)

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

### 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. Therefore, check one of the following:

- \_\_\_\_\_ *A parent or legal guardian will remain on site at all times during equine assisted activities.*  
\_\_\_\_\_ *In the event emergency treatment/aid is required, I wish the following procedures to take place:*

Date: \_\_\_\_\_ Non-Consent Signature: \_\_\_\_\_  
Participant (Parent or Guardian if participant is under the age of 18 yrs)

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

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