Above & Beyond "Ordinary" People

3600 So. Harbor Blvd. #289
Oxnard, CA 93035
(805) 217-2776

APPLICATION FORM

Student's Name___________________________________ D.O.B.________________

Address____

City______________________________________ State_________ Zip________________

Home Phone____________________________________ Work Phone ________________

Height____________________ Weight________________ Age__________________

Emergency Information

Parent/Guardian____

Address____

City____State__________ Zip___________

Home Phone____________________________________ Work Phone___________________

1. Briefly describe nature of disability (if any) ____

   ____

2. If you have an extremity involvement, please indicate and describe: ______________________

   ____

3. Check mobility level
   _____ Walks unassisted _____ Uses crutches
   _____ Walks assisted _____ Uses walker
   _____ Wears braces _____ Uses wheelchair
   If wheelchair is used, can you sit erect without support straps?
   _____ Yes _____ No

4. What would you like to achieve from the riding program? ______________________________

   ____

5. Have you had any previous experience with horses?__________________________________

   ____

Above & Beyond "Ordinary" People, A Therapeutic Riding Program

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Riders Medical History and Physician's Statement

Date: ______________________________

NAME: ____ DOB: ____/____/____ AGE_____

SEX: ___________ HEIGHT: ___________ WEIGHT: _________ PULSE: _________ B.P.:_________

DIAGNOSIS: ____

CAUSE: ____

MEDICATIONS (Type, Purpose, Dose): ____

____

If Downs Syndrome, Atlanto-Axial Subluxation? Yes _____ No_____

Cervical X-ray for Atlanto-Axial Subluxsation: Positive _____ Negative _____ X-ray Date: ____/____/____

Tetrus Shot: Yes _____ No_____ Date: ____/____/____

Please Indicate of the client has or has a history of the following secondary problems by checking yes or no. If YES, please include COMPLETE information pertaining to the problem.

PROBLEM	YES	NO	IF YES, OR HISTORY OF, DESCRIBE
AUDITORY IMPAIRMENT	___	___	________________________________
LEARNING DISABILITY	___	___	________________________________
MENTAL IMPAIRMENT	___	___	________________________________
PSYCHOLOGICAL IMPAIRMENT	___	___	________________________________
SPEECH IMPAIRMENT	___	___	________________________________
VISUAL IMPAIRMENT	___	___	Glasses__________________________
ALLERGIES	___	___	________________________________
CARDIAC	___	___	________________________________
CIRCULATORY	___	___	________________________________
PVD	___	___	________________________________
Postural Hypotension	___	___	________________________________
Hemophilia	___	___	________________________________
PULMONARY	___	___	________________________________
Asthma	___	___	________________________________
NEUROLOGICAL	___	____	________________________________
Seizures	___	____	________________________________
Controlled			
Last Seizure: ____/____/____			
Hydrocephalus	___	___	________________________________
Shunt	___	___	________________________________
Sensory Loss	___	___	________________________________
Pain	___	___	________________________________

PROBLEM	YES	NO	IF YES, OR HISTORY OF, DESCRIBE
MUSCULAR	___	___	________________________________
SKELETAL			
Spinal Column Injury	___	___	________________________________

Subluxing Joints ___ ___ ____

Dislocating Joints ___ ___ ____

Laminectomy ___ ___ ____

Scoliosis – Degree/Type/
Brace/Last X-ray ___ ___ ____

Kyphosis/Lordosis
Degree/Type ___ ___ ____

Spondylolisthesis ___ ___ ____

Spinal Abnormality ___ ___ ____

Osteoporosis ___ ___ ____

Heterotrophis Ossification ___ ___ ____

Joint Disease ___ ___ ____

Cranial Defects ___ ___ ____

Fractures ___ ___ Location? ______________________________ Healed? ____________________

Other___________________ ___ ___ ____

MEDICAL HISTORY

Please indicate any medical problems not indicated above.

Please indicate special precautions:

MOBILITY STATUS

Ambulatory? Yes_____ No_____

Can the student ambulate independently? Yes_____ No_____
If No, describe: ____

PROSTHETICS/ORTHODONTICS:

Type: ____ Purpose: ____

Type: ____ Purpose: ____

Please describe any other additional information that might help us to work with this student. Thank you for your time

Physician's Signature: ____ Date: ______________________

Physician's Name (Please Print): ____

Physician's Address: ____

Telephone Number: ____- ____-________

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Authorization for Emergency Medical Treatment

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___________________________ (Operating Center's Name) 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.

Client's name: ____ Phone: __________________

Address: ____

In the event I cannot be reached, contact: __________________________ Phone: _________________

contact: __________________________ Phone: _________________

Physician's Name: ____ Phone: _________________

Preferred Medical Facility: ____

Health Insurance Co.: ____ Policy #:________________

Consent Plan

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 listed below is unable to be reached.

Date: __________________________ Consent Signature _____________________________________
Client, Parent or Guardian

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. In the event emergency treatment/aid is required, I wish the following procedures to take place:

____

____

____

____

Date: _________________________ Non-Consent Signature____
Client, Parent or Guardian

Print Name____ Phone: _________________

Address: ____

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM

Above and Beyond "Ordinary" People

A Therapeutic Riding School

PHOTO RELEASE FORM

For valuable consideration given and which is hereby acknowledge, the undersigned hereby grants to Above and Beyond "Ordinary" People permission to take or have taken still and moving pictures and films including television pictures for

(Print name)____,

and consents and authorizes Above and Beyond "Ordinary" People, its advertising agencies, news media and any other persons interested in Above and Beyond "Ordinary" People and its work, to use and reproduce the photographs, films and pictures and to circulate and publicize the same by all means including, without limiting the generality of the foregoing, newspapers, television media, brochures, pamphlets, instructional material, books and clinical material. With respect to the foregoing matters, no inducements or promises have been made to us/me to secure our/my signature(s) to this release other than that intention of Above and Beyond "Ordinary" People to use or cause to be used such photographs, films and pictures for the primary purpose of promoting and aiding Above and Beyond "Ordinary" People and therapeutic riding.

DATED____

____
Signature

____
Print name of parent or guardian

Rancho Royale

10480 Creek Rd. Oak View, CA

Release of Liability and Assumption of Risk

Owner/Rider

This Agreement entered into on this ___________________day of______________________, 20___________,
By and between Rancho Royale, hereinafter referred to as RR and

(Print name) ____, hereinafter referred to as RIDER

and if RIDER is a minor, RIDER"S parent or guardian ____, for the use today and on all future dates, of the property, facilities and services of RR, RIDER, RIDER'S heir, assigns and representatives hereby agree as follows:

Inherent Risks and Assumption of Risk. The undersigned acknowledge there are inherent risks associated with equine activities such as described below and herby expressly assume all risks associated with participating in such activities. The inherent risks include, but are not limited to the propensity of equines to behave in ways such as running, bucking, biting, kicking, shying, stumbling, rearing, falling or stepping on, that may result in injury or death to persons on or around them; the unpredictability of equines reaction to their surroundings; certain hazards such as surface and subsurface conditions; and the potential of a participant to act in a negligent manner that may contribute to injury to the participant or others such as failing to maintain control of the animal. RIDER acknowledges that horses by their very nature are unpredictable. RIDER assumes all risks in connection therewith and expressly waives and claims for injury, loss or damages arising there from. RIDER agrees to abide by RR rules and regulations which shall be posted and/or available from management.

YOU ARE ADVISED THAT THERE ARE INHERENT RISKS, INCLUDING THE RISK OF SERIOUS INJURY OR DEATH, WHILE ENGAGING IN EQUINE ACTIVITIES. BY ENGAGING IN EQUINE ACTIVITIES AND IN ACCORDANCE WITH THE TERMS OF THIS AGREEMENT YOU HEREBY ASSUME ALL RISKS OF INJURY OR DEATH.

Release of Liability. RIDER agrees to hold harmless, indemnify and defend, RR, the owners, operators, agents, employees, landowners thereof, against any and all claims, demands, causes of action, damages, liabilities, judgments, orders, costs or expenses including attorney's fees which in any way may be connected, directly or indirectly, with RIDERS use or presence upon herein said property and the facilities thereon. In the even the rider is a minor, the parent or guardian shall further indemnify, defend and hold harmless, RR, the owners, operators, agents, employees and landowners thereof from any such claims by said minor child.

Name ____

Address____Phone ___________________________

DOB if RIDER is a minor ______________ ___________Guests: I am a guest of ______________________________

X____ Date ______________________________

Authorization to Obtain Medical Treatment for Minor

RR is hereby authorized to obtain any and all medical treatment RR deems reasonably necessary for my minor child or children including emergency transport by ambulance to any emergency room. Parent or guardian agrees to bear any cost connected therewith. RR shall incur no financial responsibility pursuant to this authorization.

____

Parent or Guardian Signature Date