

Front Range Exceptional Equestrians  
PO Box 272452 Ft. Collins, CO 80527-2452  
(970) 221-0646 voice mail



### CLIENT APPLICATION/ HEALTH HISTORY

\_\_\_\_\_  
**CLIENT'S** Name                      Date of Birth                      Height                      Weight                      Today's Date

**Whom should we contact for scheduling classes?** \_\_\_\_\_  
**Contact Name**

\_\_\_\_\_  
**Contact Mailing Address—Street, City, State, Zip+4**                      **Contact Phone**  
**Parent/Guardian Address and Phone (if minor)** \_\_\_\_\_

E-Mail address \_\_\_\_\_

\_\_\_\_\_  
School or Group Home placement                      Physician Name/Phone

Please list type of therapy the client is currently receiving with Therapist Name/Phone:

\_\_\_\_\_

How did you hear about our program? \_\_\_\_\_

Are you a returning rider that has participated in our program previously? \_\_\_\_\_

Diagnosis \_\_\_\_\_ Current Medications: \_\_\_\_\_

**To help us place the client in an appropriate class, and work effectively with him/her, please check any of the following that describes the client:**

**Communication Ability:**    \_\_\_ Uses language normally    \_\_\_ Uses Sign Language/finger spelling  
\_\_\_ Understands spoken language    \_\_\_ Uses nonverbal communication    \_\_\_ Hearing Impaired  
\_\_\_ Client's speech is difficult to understand    \_\_\_ Responds slowly to verbal communication  
\_\_\_ Client's speech is usually understood    \_\_\_ Does not respond to verbal communication

Communication aids used by client are: \_\_\_\_\_

**Physical Skills:**    \_\_\_ Sits independently    \_\_\_ Uses hands well    \_\_\_ Transfers independently  
                         \_\_\_ Walks independently    \_\_\_ Uses hands fairly well    \_\_\_ Stands with help  
                         \_\_\_ Stronger Left/ Right side    \_\_\_ Does not use hands    \_\_\_ Cannot stand/ walk

Mobility aids used by client are: \_\_\_\_\_

**Social Skills:** Does client typically cope well with new people and new situations? YES    NO

Has the client ever participated in therapeutic riding classes before? If so, where? \_\_\_\_\_

Does the client exhibit any behaviors which may affect his/her ability to benefit from our program or to work with an Instructor or volunteers in a group setting? Please explain. \_\_\_\_\_

Does the client have any fears we should know about (animals, heights, falling)? \_\_\_\_\_

**Health History:** Please indicate if the client has any current or past problems in the following areas.  
Please explain any Yes answers.

Health Area	Yes	NO	Comments
Heart/Circulation			
Breathing			
Asthma			
Chronic Pain			
Skin Ulcers			
Vision			
Bone/Joint			
Allergies			
Behavior			

**To the best of my knowledge, I confirm that the information I have provided is true and correct at this time.**

\_\_\_\_\_ **Date** \_\_\_\_\_  
*Client, Parent, or Legal Guardian*

**PHOTO RELEASE**

I **DO/ DO NOT** (circle one) consent to and authorize the use and reproduction by Front Range Exceptional Equestrians of any and all photographs and other audiovisual materials taken of me/ my child/ my ward for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the Front Range Exceptional Equestrians program.

\_\_\_\_\_ **Date** \_\_\_\_\_  
*Client, Parent, or Legal Guardian*

**Everyone must complete and sign these releases before participating in our program. If you are under 18 a parent or guardian must sign.**

**EMERGENCY TREATMENT RELEASE**

Rider Name \_\_\_\_\_ Parent/Guardian Name (if minor) \_\_\_\_\_

Address \_\_\_\_\_

Phone (Day) \_\_\_\_\_ Evening \_\_\_\_\_

**Whom shall we call in case of emergency during time at Front Range Exceptional Equestrians:**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

Please list any health condition which may affect your safety and that emergency personnel should be aware of (i.e. allergy, asthma, diabetes, seizures, hearing impairment, etc.)

Please list any special medical problems in case of emergency i.e. allergy to medication, bee sting, etc)

**Consent for Medical Treatment**

**I give my consent** for emergency medical treatment/aid in the case of illness or injury during my/my child's participation in the Front Range Exceptional Equestrians program or while being on the property of the agency. This authorization includes x-rays, surgery, hospitalization, medication and any treatment deemed "life saving" by the emergency physician.

**Consent signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Non-consent for Medical Treatment**

**I DO NOT give my consent** for emergency medical treatment in the case of illness or injury while participating in the Front Range Exceptional Equestrians program or while being on the property of the agency. **If emergency treatment/aid is required, the following should occur:** \_\_\_\_\_

**FOR ALL PARTICIPANTS UNDER 18 A PARENT or GUARDIAN WILL BE PRESENT ON SITE AT ALL TIMES.**

**Non-consent signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**LIABILITY RELEASE**

**WARNING: Under Colorado law, an equine professional is not liable for an injury to or death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to Section 13-21-119 Colorado Revised Statutes.**

\_\_\_\_\_ (Name) requests participation in the Front Range Exceptional Equestrians therapeutic riding program. I acknowledge the risks and potential risks of injury during horseback riding therapy and working with horses. However, I feel that the possible benefit to myself/ my child/ my ward warrants assumption of these risks. I hereby, intending to be legally bound, for myself, my heirs, and my assigns, executors and administrators, waive and release forever all claims for damages against Front Range Exceptional Equestrians, its Board of Directors, Instructors, Therapists, Aides, Volunteers, Horse Owners, Property Owners, and/or Employees for any and all injuries and/or losses that I/ my child/ my ward may sustain while participating in Front Range Exceptional Equestrians therapeutic riding program.

\_\_\_\_\_  
**Signature of person releasing liability**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Relationship to client**

**REMEMBER  
HAVE YOU COMPLETED THE FOLLOWING?**

Rider's Medical History/ Physician's Consent (form is signed by Physician)	YES	NO
Client Application/Health History (form is signed and dated)	YES	NO
Emergency Treatment Release (form is signed and dated)	YES	NO
Liability Release (form is signed and dated)	YES	NO
Photo Release (form is signed and dated)	YES	NO
Areas of Learning/ Goal Sheet	YES	NO
Class Preference Form	YES	NO

**WHEN ALL FORMS ARE SIGNED AND COMPLETED PLEASE RETURN  
TO:**

**Front Range Exceptional Equestrians  
PO BOX 272452  
Fort Collins, CO 80527-2452**

YOU WILL BE NOTIFIED WHEN YOU ARE PLACED IN A CLASS  
THANK YOU