

Phone  
(262) 882-3470  
Fax  
(262) 882-5661



E-mail  
[classes@smiles.nu](mailto:classes@smiles.nu)  
Website  
[www.smiles.nu](http://www.smiles.nu)

## ONE-TIME RIDERS REGISTRATION AND RELEASE FORM (website form)

DATE: \_\_\_\_\_ RIDER'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
STREET: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_  
COUNTY: \_\_\_\_\_ HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
PARENTS OR GUARDIAN \_\_\_\_\_ School/Group \_\_\_\_\_  
PRIMARY DISABILITY: \_\_\_\_\_ OTHER DISABILITIES \_\_\_\_\_  
ADAPTATIONS: \_\_\_\_\_ HAS STUDENT EVER RIDEN A HORSE: \_\_\_\_\_

### PHYSICIANS RELEASE

DIAGNOSIS \_\_\_\_\_ DATE OF ONSET \_\_\_\_\_

**NOTE: IF DOWN SYNDROME, EVALUATE FOR ATLANTOAXIAL INSTABILITY.**  
DATE OF X-RAY \_\_\_\_\_ POSITIVE \_\_\_\_\_ NEGATIVE \_\_\_\_\_

**Present medical and functional status (i.e. visual/audio limitations, seizures, balance, etc)** \_\_\_\_\_

### Allergies

**In my opinion, this patient can receive therapeutic horseback riding instruction under appropriate supervision.**

**Physician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

### LIABILITY RELEASE

\_\_\_\_\_(Rider's name) would like to participate in the SMILES program. I acknowledge the risks and potential for risks of horseback riding. However, I feel 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 SMILES, its board of Directors, Instructors, Therapist, Aids, Volunteers and/or Employees for any and all injuries and /or losses I/my son/my daughter/my ward may sustain while participating in SMILES program.

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

### PHOTO RELEASE

I hereby consent to and authorize the use and reproduction by SMILES 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 or for any other use for the benefit of the program (Signature of this release is optional.)

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

**(PLEASE SEE OTHER SIDE)**

## EMERGENCY NUMBERS

IN CASE OF AN EMERGENCY CONTACT: \_\_\_\_\_ PHONE \_\_\_\_\_

OR CONTACT: \_\_\_\_\_ PHONE \_\_\_\_\_

### RIDER'S AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

In the event of an 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 SMILES 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 \_\_\_\_\_

Or contact \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Name: \_\_\_\_\_ 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 below is unable to be reached.

Date: \_\_\_\_\_ Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

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

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

Date: \_\_\_\_\_ Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Non-consent Signature: \_\_\_\_\_

Client, Parent or Guardian

(Website form)