HEC Hooves of Joy, Inc

Therapeutic Horsemanship Center

65395 Highland Road Ashland WI, 54806
PH: 715.682.2558 hechoovesofjoy@gmail.com

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Client Registration Form

***Required information**
*Client Name: _____
*Phone:_____ Email: _____
*Street:_____*City:_____*Zip:_____
*Date of Birth: _____ *Age:_____ *Height:_____ *Weight:_____
*Parent/Guardian: _____Relationship: _____
*Phone:_____Email:_____
Second Phone:_____ Email_____
*What phone number is best used in the event of lesson cancellation? _____
What email is best used in the event of lesson cancellation? _____
In case of an emergency, is there someone we should call? ☐ Yes ☐ No
Contact & Relationship _____ Phone _____
Is there any emergency information or procedures you would like us to follow in case of emergency? (Attach additional pages as needed.) _____
_____

Please indicate which session(s)you are interested:
☐ Session 1 Monday ☐ Session 2 Tuesday ☐ Session 3 Thursday

Client is: ☐ **New to Hooves of Joy:** Please also complete the following required forms:

- Client Release Form
- Medical History & Physician Statement (MUST be signed)
- Assessment (your 1st session)

☐ **Returning:** year last participated_____
If returning, has client had any changes in medical history or medications?
☐ No ☐ Yes
*If yes is indicated, please describe changes below and fill out new Medical History & Physician Statement.
HEC Hooves of Joy reserves the right to request updated Medical History & Physician Release at any time.

_____
_____
_____

HEC Hooves of Joy Policies

- Fees: Therapeutic Riding & Un-mounted Activities vary per program. One-time assessment fee of $50 applies for all new clients.
- Requests for Payment Plans must be received prior to the session for which you are participating in.
- Payment will be refunded if client is unable to participate in appropriate class and activity, and/or if HEC Hooves of Joy is notified of conflict prior to the start of the session. A credit, less any processing fees will be applied to the account for withdrawal after the start of the session. NO REFUNDS OR MAKEUPS will be offered for vacations, temporary illness, or unanticipated circumstances. Refunds will be given if a client withdraws for the entire session due to medical necessity with written notification from client's medical provider.
- Rider/family is directly responsible for amounts not authorized or paid for by third party billing sources.
- Reschedule or Credit will be applied to client's account when HEC Hooves of Joy initiates cancellation of lesson or session. Credits must be used by end of following calendar year, meaning credits carried from 2019 must be used by end of 2020.
- Clients with inappropriate shoes (including crocs, sandals, open-toed or open-heeled) and clothing, or clients arriving more than 10 minutes late for activities, will not be able to join their class. Fees will not be refunded.
- NO DOGS allowed on HEC Hooves of Joy grounds.

I have read, understand and agree to HEC Hooves of Joy lesson policies.

Client Print Name:_____ **Date:**_____

Signature:_____**Date:**_____
Client (over age 18), Parent or Guardian

HEC Hooves of Joy has many family members & riders involved behind the scenes (serving as board/committee members, volunteering with special events, fundraising or helping around the farm). Do you have any skills or interests you are willing to share?

_____

_____

*If your bill should be directed to another party, please list name & address here:_____

_____

Client Release Form

Client_____ Phone:_____ Email:_____
Address:_____ City:_____ Zip_____

Parents/Guardian(s): _____

Address(if different from client)_____

Parent/Guardian Contact (Phone & Email)_____

Liability Release (REQUIRED) In return for being allowed to use the HEC HOOVES OF JOY, Inc. Therapeutic Horsemanship Program, including its facilities, horses and equipment, where applicable for horseback riding and other horse related activities, I/my son/my daughter/ my ward (Client's Name) _____ agree to abide by all the rules and regulations of HEC HOOVES OF JOY, Inc. now in effect or later adopted. In addition, I hereby agree to assume all responsibility and risk from my/my son/my daughter/my ward's participation in activities of HEC HOOVES OF JOY Inc. I further agree to hold HEC HOOVES OF JOY, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees free and harmless from all damages or liability for any injury to person or property arising as a result of the use of facilities, horses and or equipment owned or leased to HEC HOOVES OF JOY, Inc., including any injury caused by their negligence.

I am aware of the significant risks of injury that horseback riding and horse-related activities may cause to myself/my son/my daughter/my ward, however I feel that the possible benefits to myself/my son/my daughter/my ward are greater than and out weigh the risk assumed. By signing this agreement I am assuming all risk and do hereby understand that horses are animals, not subject to any guarantee of reliability. Therefore, I agree to release, indemnify and hold harmless HEC HOOVES OF JOY, Inc., the Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees from all liability they may incur.

In accordance with the Wisconsin Law relating to the limitation of civil liability regarding equine activities: "NOTICE: A person who is engaged for compensation in the rental of equines or equine equipment or tack or in the instruction of a person in the riding or driving of an equine or in being a passenger upon an equine is not liable for the injury or death of a person involved in the equine activities resulting from the inherent risks of equine activities, as defined in section 895.481 (1) (e) of the Wisconsin Statutes."

Signature: _____ Date:_____

Client if over age 18, Parent or Guardian

Print Name: _____ Phone: _____

Photo Release (REQUIRED

❒ **I Do** ❒ **I Do Not** consent to and authorize the use and reproduction by HEC HOOVES OF JOY, Inc. of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Exceptions:_____

Signature:_____ Date:_____

Client if over age 18, Parent or Guardian

Print Name_____Phone: _____

New and Returning Clients

GOALS (What would you like to gain from this experience?_____

_____

_____

New Clients Only

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

 PHYSICAL (Mobility skills such as transfers, walking, wheelchair use, etc)

_____

_____

_____

 PSYCHO/SOCIAL (work/school, leisure interests, companion animals, fears/concerns)

_____

_____

_____

 OTHER INFORMATION YOU WOULD LIKE TO SHARE_____

_____

_____

_____

Return to: HEC HOOVES OF JOY, INC.

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PATH INTERNATIONAL
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Client Medical History &Physician's Statement

*Participant: _____ DOB: _____ *Height:_____ *Weight:_____
Address:_____ City:_____ State:_____ Zip:_____
*Phone:_____Email:_____
*Diagnosis:_____ Date of Onset:_____
Past/Prospective Surgeries:_____
Medications: _____For:_____
Seizure Type: _____ Controlled: Y N Date of last Seizure:_____
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices: _____Shunt Present: Y N Date of Last Revision:_____
For those with Down syndrome: Neurologic Symptoms of Atlantoaxial Instability: ☐Present ☐Absent
Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

- Auditory no yes _____
- Visual no yes _____
- Tactile Sensation no yes _____
- Speech no yes _____
- Cardiac no yes _____
- Circulatory no yes _____
- Integumentary/Skin no yes _____
- Immunity no yes _____
- Pulmonary no yes _____
- Neurologic no yes _____
- Muscular no yes _____
- Balance no yes _____
- Orthopedic no yes _____
- Allergies no yes _____
- Learning Disability no yes _____
- Cognitive no yes _____
- Emotional/Psychological no yes _____
- Pain no yes _____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that the PATH Intl Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl Center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____MD DO NP PA Other_____
Address: _____ City: _____State:_____ Zip:_____
Phone:_____ License/UPIN Number:_____
Signature:_____ Date:_____