To apply as a rider at Pegasus Therapeutic Riding here after referred to as Pegasus, the enclosed application must be completely filled out. This information is necessary for the rider’s safety. Applications not completely filled out will be returned.

The Rider will be scheduled into a class when the application is approved. No applicant will be allowed on a horse until the application is received and approved.

Enclosed you will find the following: Signatures are required.

- REGISTRATION
- PHYSICIAN REFERRAL - SIGNED AND STAMPED
- LIABILITY RELEASE
- AUTHORIZATIN TO TREAT MINORS / ADULTS
- PHOTO RELEASE

FILL OUT THIS FORM, AND RETURN COMPLETED TO THE MAILING ADDRESS BELOW.

Should you have any further questions, please leave a message at the Pegasus Ranch Office. One of our staff will contact you. The phone number is: 760-772-3057

RANCH DIRECTIONS: 10 Freeway ~ Exit Cook Street ~ North on Cook Street ~ Cross Varner Road ~ Chase School Road Turn Right ~ Continue To The Pegasus Ranch ~ Paved Road Turns Into Dirt Road. See map on our website.

MAILING ADDRESS: Pegasus Therapeutic Riding
35-450 B Pegasus Court
Palm Desert, CA 92211
760-772-3057

Pegasus Therapeutic Riding
501 (c ) NONPROFIT CORPORATION FEDERAL TAX ID 95-3774003
www.pegasusridingacademy.org
REGISTRATION

Date: ____________

Applicant’s Name (print) __________________________________________ Age: __________________
Address: __________________________________________ City: __________________
Phone: AM: ___________________________________________ PM: _______________________
Date of Birth: ____________ SS# __________________________

Parent / Guardian Authorization: print: __________________________ signature: __________________________

Parent / Guardian Employer: _____________________________________________________________________________

INSURANCE INFORMATION

Insurance: __________________________________________________________
Address: __________________________________________________________

Medicare Number: _______________________________ Medical Number: _______________________________ Certificate Number: _______________________________
Group Number: _______________________________ Policy Number: _______________________________ Code: _______________________________

MEDICAL INFORMATION

Physician’s Name (Print) __________________________________________________________
Physician’s Address: _____________________________________________________________________________
Disability: __________________________ Date of Onset: __________________________
Medications: __________________________________________________________
Allergies to food, drugs, or animals: __________________________ Last Tetanus Toxoid Booster: __________________________
Special Medical Conditions (feeding tubes, shunts, hearing aids) etc.: __________________________

PARENT OR GUARDIAN DAYTIME CONTACT NUMBERS: WORK OR HOME OR CELL

Contact __________________________ Phone: __________________________

Form: 4-5-12
DATE: __________________

MEDICAL HISTORY: MUST BE FILLED OUT AT THE DOCTORS OFFICE WITH PHYSICIAN’S SIGNATURE AND STAMP

APPLICANT / PATIENT 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 Subluxation:  Positive ___________ Negative _________  X-ray Date: ______/_____/________

Tetanus Shot:  Yes ________ No ________ Date: __________ / ___________ / ___________
______________________________________________________________________________

MOBILITY STATUS:

Ambulatory?     Yes ____________   No ______________

Can the patient ambulate independently?   Yes_________ No ___________
If No, describe: ____________________________________________________________________ ______

PROSTHETICS / ORTHOTICS:

Type: _______________________________   Purpose: __________________________________________

Type: _______________________________   Purpose: __________________________________________
Please describe any other additional information that might help us to work with this Applicant / Patient.

____________________________________________________________________________________________

Please indicate if the Applicant / Patient has or has / had a history of the following secondary problems by checking yes or no. If YES, please include COMPLETE information pertaining to the problem.

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>Yes</th>
<th>No</th>
<th>IF YES, History of, Describe</th>
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<tbody>
<tr>
<td>Auditory Impairment</td>
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<tr>
<td>Learning Disability</td>
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<td>Mental Impairment</td>
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<td>Psychological Impairment</td>
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<td>Speech Impairment</td>
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<td>Visual Impairment</td>
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<td>Allergies</td>
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<td>Cardiac</td>
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<td>Asthma/COPD</td>
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<td>Neurological</td>
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<td>Seizures</td>
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<td>Controlled</td>
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<td>Last Seizure: <strong>/</strong>/_______</td>
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<td>Hydrocephalus</td>
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<td>Pain</td>
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<td>Muscular Contractures</td>
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**SKELETAL**

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<tr>
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<th>Yes</th>
<th>No</th>
<th>IF YES, History of: Describe</th>
<th>Yes</th>
<th>No</th>
<th>Explain</th>
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<tr>
<td>Spinal Column Injury</td>
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<td>Heterotrophis Ossification</td>
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<td>Subluxing Joints</td>
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<td>Joint Disease</td>
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<td>Dislocating Joints</td>
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<td>Laminectomy/Fusion</td>
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<td>Scoliosis-Degree/Type</td>
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<td>Kyphosis/Lordosis</td>
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<td>Craniocerebral Anomalies</td>
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<td>Degree/Type</td>
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<td>Fractures</td>
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<td>Other</td>
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<tr>
<td>Spinal Abnormality</td>
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<td>Osteoporosis</td>
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</table>
MEDICAL HISTORY

Please indicate any medical problems not indicated on pages 2 & 3:
____________________________________________________________________________________________________________________

Please indicate special precautions:
____________________________________________________________________________________________________________________

________________________________________________________ Date: ____________________
Physician’s Signature: ________________________________________ Date: __________________
Physician’s Name: (Please Print) ___________________________________________
Physician’s Address: ____________________________________________________
Telephone Number: __________ - __________ - ________________

PHYSICAL THERAPY ASSESSMENT IF APPLICABLE:

PATIENT: _________________________________________________ Date of Birth: ___________________
School Placement_____________________________________
Disability: ___________________________________________________________________
Ambulatory: Y / N____ Muscle Tone: _____________
Sensation: ___________________________________________________________________
Rom Limitations: __________________________________________
Balance / Equilibrium: _____________ Other Structural Abnormalities: _____________
Equipment: __________________________________________
Evaluation Summary_______________________________ Precautions or Restrictions _________________________________________________________
Suggested Exercises: __________________________________________
Physical Therapist (Names) ___________________________________________
Address: _________________________________________________________________________________________________________________________
Phone: ________________________________ Signature: _____________________________________
SIGNATURES REQUIRED FOR EACH WAIVER / RELEASE BELOW

DATE:___________

APPLICANT:__________________________________________

This Applicant is represented for all releases and waivers as follows below. To participate in the Pegasus program, I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to me / 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 Pegasus, and its Board of Directors, Instructors, Therapists, Aides, Volunteers and / or Employees for any and all injuries and / or Losses I / my son / my daughter / my ward may sustain while participating in Pegasus.

Print Name: ______________________________________ Signature: _________________________________________ Date: ____________

APPLICANT: ________________________________________

AUTHORIZATION TO TREAT A MINOR

I / WE, the undersigned parent, parents or legal guardian of Client / Rider named above, a minor, do hereby authorize and consent to any X-ray examination, anesthetic, medical or surgical diagnosis rendered under general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act, a Dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute General Hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that every effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions:_____________________________________________________________________________________________________

Print Name:______________________________________ Signature: ________________________________________ Date: _______________

Circle Relationship to Applicant: Father, Mother, or Legal Guard

This consent, release and waiver form shall remain effective until the expiration of this form which is three years from date.

EMERGENCY CONTACT NUMBERS:  IN CASE OF A DAYTIME EMERGENCY PLEASE CALL

PRINT NAME:_______________________ CELL _________________

PHOTO RELEASE

For valuable consideration given and which is hereby acknowledged, the undersigned grants to Pegasus permission to take or have taken still and moving photographs and films including television pictures of our / my son, daughter, ward. By signing this the Rider, Parent or Guardian, consents and authorizes Pegasus, its advertising agencies, news media, and other persons interested in Pegasus and its work, to use and reproduce the photographs, films and pictures to circulate and publicize the same by all means including without limiting the generality of the foregoing newspapers, television media, brochures, films, 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 the intention of Pegasus to use or cause to be used, such photographs, films and pictures for the primary purpose of promotion and aiding Pegasus for the Handicapped and its work.

 PHOTOS AUTHORIZED: Signature:__________________________ Date:________________________

If the Rider, Parent or Guardian DO NOT want Photos taken under any circumstances, YOU MUST CIRCLE “NO PHOTO'S” AND SIGN BELOW

NO PHOTOS: Signature of Applicant, Parent or Guardian

Requesting no photos be taken

NOTE: IF YOU DO NOT CIRCLE "NO PHOTOS AND SIGN, PICTURES MAY BE TAKEN!}
QUALIFICATIONS / RIDERS DRESS CODE

Dear Riders, Parents, Caregivers and Teachers; Please keep this page for your information.

QUALIFICATIONS

- **Adults:** Riders must be deemed handicapped by the Social Security system
- **Children:** Riders must be deemed handicapped by the Public School system
- All applicants must complete the “Rider’s Packet” which MUST include a Doctors signed approval for applicant to participate in the program
- We accept riders 3 years of age to late 80’s
- Weight maximum: 190 lbs., **no exceptions** for SAFTEY of the rider, horse and volunteer.

RIDER’S DRESS CODE:

For a safe and beneficial ride we ask that everyone follow the dress code below. If the dress code is not followed the rider may be asked not to ride that week. Again these rules are for the safety of the rider.

- **Long pants:** to protect riders legs from chaffing and getting pinched in saddle straps
- **Closed toe shoes,** sneakers and boots are good, **NO SANDALS or FLIP FLOPS.** If a rider is wearing any open toe shoes, sandals or flip flops they **WILL NOT BE ALLOWED TO RIDE.**
- **No dresses or skirts**
- **Tops,** anything comfortable, keep in mind weather conditions
- **HELMETS:** Are provided by Pegasus and MUST be worn. Our Helmets comply with all state safety codes. Riders can bring their own helmet as long as it complies with state safety code.

Please call the ranch (760) 772.3057, if you have any questions and leave a message.

Thank you,

Chase Berke, VP Program Director
Karen Renberg, VP Operations