PEGASUS

Therapeutic Riding

All Special Needs, All Ages

CLIENT / RIDER APPLICATION

NAME____ **DATE**_____________

PRINT Applicant's Name

Attends What School? OR Adult ____

To apply as a client at Pegasus Therapeutic Riding for the disabled, the enclosed application must be completely filled out to be accepted. This information is necessary for the client's safety. Applications not completed will be returned.

The client will be scheduled into a class when the application is approved and /or an opening becomes available. 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 – *Need Doctors* SIGNATURE AND OFFICE STAMP**

________**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 Pegasus Stables/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, POBOX 13508, Palm Desert, CA. 92255-3588

FACILITY ADDRESS: Pegasus Therapeutic Riding, 35-450 B Pegasus Court Palm Desert, CA 92211 Phone: 760.772.3057

NON-PROFIT 501 (C) (3) CORPORATION FEDERAL TAX ID 95-3774003
www.PegasusRidingAcademy.org

REGISTRATION

Date: ____________

Applicant's Name (print)____Age: ________________

ATTENDS WHAT SCHOOL? ____

Address: ______________________________City__________________State____________Zip__________

Phone(s) ____________________ **EMAIL REQUIRED** _________________________________

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: _________________________________

Pegasus Therapeutic Riding 35-450 B Pegasus Court, Palm Desert, CA 92211, Phone: 760.772.3057

Form: 5.2.19 CB

Pegasus Therapeutic Riding, 35-450 B Pegasus Court, Palm Desert, CA 92211, Phone: 760.772.3057

MEDICAL HISTORY

DATE: ________________

MUST BE FILLED OUT AT THE DOCTORS OFFICE WITH PHYSICAN'S SIGNATURE AND STAMP ON NEXT PAGE

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: _________________________________

MEDICAL HISTORY CONTINUED

Date: ________

Please describe any other additional information that might help us to work with this Applicant / Patient.

____

Please indicate if the Applicant / Patient have 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.

PROBLEM	Yes	No	IF YES, History of, Describe
Auditory Impairment	______	_____	________________________
Learning Disability	______	_____	________________________
Mental Impairment	______	_____	________________________
Psychological Impairment	______	_____	________________________
Speech Impairment	______	_____	________________________
Visual Impairment	______	_____	Glasses: ________________
Allergies	______	_____	________________________
Cardiac	______	_____	________________________
Circulatory PVD	______	_____	________________________
Postural Hypotension	______	_____	________________________
Hemophilia	______	_____	________________________
Asthma/COPD	______	_____	________________________
Neurological			
Seizures	______	____	Controlled___________ Last Seizure:_______
Hydrocephalus	______	_____	________________________
Shunt, if yes, where?	______	_____	________________________
Sensory Loss	______	_____	________________________
Pain	______	_____	________________________
Muscular Contractures	______	_____	________________________

PROBLEM	Yes NO	IF YES, History of: Describe		Yes or No	Explain
SKELETAL		_______________	Heterotrophis Ossification_	Y / N	_________________
Spinal Column Injury	Y / N				
Subluxing Joints	Y / N	________________	Joint Disease	Y / N	________________
Dislocating Joints	Y / N	________________			
Laminectomy/Fusion	Y / N	________________			
Scoliosis Degree/Type	Y / N				
Brace Last X-ray	Y / N	____________________			
Klyphosis/Lordosis Degree/Type	Y / N	____________________	Cranial Defects _________________________		
			Fractures ___________________________		
Spondylolisthesis	Y / N_	____________________	Other_________________________________		
Spinal Abnormailty	Y / N	____________________			
Osteoporosis	Y / N	____________________			

MEDICAL HISTORY CONTINUED

Date: ________

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

____

Please indicate special precautions:

____

Physician's Signature: ______________________________ **Date:** ____________________

Physician's Name: (Please Print) ______________________________________

Physician's Address: ____

Telephone Number: ________-_________-_____________

PHYSICIAN'S STAMP

PHYSICAL THERAPHY 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: ____________________________

LIABILITY RELEASE

DATE:_________

SIGNATURES **REQUIRED FOR EACH (3) WAIVER / RELEASES BELOW**

APPLICANT: (Print Name)____

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 all injuries and / or Losses I / my son / my daughter / my ward may sustain while participating in Pegasus.

Print Name:_______________________ *Signature*:____________________________________ Date:__________

Applicant, Parent or Guardian Applicant, Parent or Guardian

AUTHORIZATION TO TREAT A MINOR or ADULT CLIENTS

I/WE, the undersigned applicant, parent, parents or legal guardian of Client/Rider named above, a minor or adult, 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 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**: Self, Father, Mother, or Legal Guard

This Liability Release remains in effect until an updated release is received.

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

PRINT NAME:__________________CELL______________ **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 and 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.

YES, PHOTOS AUTHORIZED: *Signature* _____________________________________ Date: _________

Applicant, Parent/Guardian

** ******************

If the Client, 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 *signature*

NOTE: IF YOU DO NOT CIRCLE "NO PHOTOS AND SIGN, PICTURES MAY BE TAKEN!

Pegasus TherapeutIc Riding, 35-450 B Pegasus Court, Palm Desert, CA 92211, Phone: 760.772.3057

QUALIFICATIONS / RIDERS DRESS CODE

Dear Clients/Riders, Parents, Caregivers and Teachers;

QUALIFICATIONS **Please keep this page for your information.**

- **Adults:** Riders must be medically certified as Special Needs by Doctor or State.
- **Children:** Riders must be certified special Needs by Doctor, State / Public School system.
- All applicants must complete the "Client/Rider's Packet" which MUST include a Doctors signed approval for applicant to participate in the program.
- We accept riders 3 years of age and adults of all ages.
- **Weight maximum: 180** 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 rider's legs from chaffing and getting pinched in the saddle and 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.
- Dresses or skirts are not preferred for child's comfort and safety.
- T-shirts, blouses and sweaters/jackets 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 if it complies with state safety code.

Please call the stable (760) 772.3057, if you have any questions and leave a message, your call will be returned.

Thank you,

Chase Berke, COO, Program Director

PARENTS/ RIDERS /APPLICATE COPY