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
- 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/GuardianEmployer: __________________________________________________________________________

INSURANCE INFORMATION

Insurance: __________________________________________________________________________________________

Address: __________________________________________________________________________________________

Medicare Number: __________________ Medical Number: __________________ Certificate Number: ______________

Group Policy Number: __________________

Number: ___________________ 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
MEDICAL HISTORY

DATE: ________________

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

APPLICANT / PATIENT NAME: ___________________________ DOB: _____ / _____ / _____ AGE _____


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: __________________________

Form: 5-2-19 CB

Page 2 of 5
MEDICAL HISTORY
CONTINUED

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.

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>Yes</th>
<th>No</th>
<th>IF YES, History of, Describe</th>
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<tr>
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<tr>
<td>Shunt, if yes, where?</td>
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<td>Sensory Loss</td>
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<td>Pain</td>
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<th>NO</th>
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<th>Yes or No</th>
<th>Explain</th>
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<td>Joint Disease</td>
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<tr>
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<td>Other</td>
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</tbody>
</table>
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: _______ - _______ - ____________

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: ____________________________

Form: 5.2.19 CB  Page 4 of 5
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

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

PRINTNAME: ____________________________ CELL ______________ PRINTNAME: ____________________________ 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!”
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