



**Therapeutic Horsemanship, Inc.**

PO Box 323 • Jamesville, NY • 13078  
315 • 655 • 8943  
[info@ftguhorses.org](mailto:info@ftguhorses.org) • [www.ftguhorses.org](http://www.ftguhorses.org)

*“engaging the power of the horse  
to motivate, teach & heal”*

## Registration Form

**Participant (Rider) Name:** \_\_\_\_\_

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

**Home phone:** \_\_\_\_\_

**Alternate/cell phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**For the safety of participants, parents/caregivers are required to accompany participants to lessons and remain on site during lessons, or to make arrangements for someone to remain on site during lessons.**

**Person accompanying participant:** \_\_\_\_\_

**Relationship to participant:** \_\_\_\_\_

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

**Phone:** \_\_\_\_\_

**Person accompanying participant:** \_\_\_\_\_

**Relationship to participant:** \_\_\_\_\_

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

**Phone:** \_\_\_\_\_

**Mail completed registration form to: From the Ground Up Therapeutic Horsemanship, Inc.  
P.O. 323  
Jamesville, NY 13078**



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## **Registration Information Sheet**

- Fee for group lessons is \$30 per person per lesson. There is a maximum of three participants in each group lesson. Individual lessons are not offered at this time. There is a rider weight limit of 200 pounds. Participants must be five years old or older.
- Payment is due the 1<sup>st</sup> of the month. Please remit payment for four weeks of lessons. No refunds will be given. Make checks payable to From the Ground Up Therapeutic Horsemanship, Inc. and mail to FTGU, P.O. Box 323, Jamesville, NY 13078. Payment must be received prior to first lesson unless other arrangements have been made in advance. There will be no make-up lessons if a rider is not able to attend his or her regularly scheduled lesson.
- Generally, lessons run for 60 minutes. This may vary on any given day depending on the rider’s tolerance and the Instructor’s discretion.
- Participants must have paperwork completed by their physician prior to participation. The paperwork should accompany the initial payment. Enrollment is on a first come/first served basis. A final determination of acceptance into the program will be made after receipt of all paperwork. We do not offer back riding, also known as tandem riding.
- For safety reasons, parents and caregivers are required to accompany participants to lessons and remain on site during lessons, or to make arrangements for someone who is responsible for the participant to remain on site during lessons.
- All parents/caregivers and those who accompany participants to lessons are asked to attend one of From the Ground Up’s regular training sessions. If the need for additional volunteer help arises at a lesson, appropriately trained parents and caregivers may be asked to help out. [As such, a second Authorization for Emergency Medical Treatment form is provided in this Registration Packet for the parent/caregiver to complete for our records.] All lesson assistants are asked to wear hard soled shoes; please no sandals.



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## Participant’s Application and Health History

*(to be completed by participant or parent/legal guardian)*

### General Information

Participant Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: M F

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

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_ Alternate #: \_\_\_\_\_

Employer/School: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Parent/Legal Guardian/Caregivers: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Phone: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Phone: \_\_\_\_\_

How did you hear about the program? \_\_\_\_\_

### Health History

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

*Please indicate current or past special needs in the following areas:*

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/joint			
Muscular			
Thinking/Cognition			
Allergies			



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## Participant’s Application and Health History (cont’d)

**Medications** *(include prescription, over-the-counter, name, dose, and frequency):*

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

**Physical Function** *(i.e. Mobility skills such as transfer, walking, wheelchair use, driving/bus riding):*

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**Psycho/social Function** *(i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)*

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**Goals** *(i.e. Why are you applying for participation? What would you like to accomplish?)*

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
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**Photo Release:**            I  DO or  DO NOT *(check one)*

consent to and authorize the use and reproduction by From the Ground Up Therapeutic Horsemanship, Inc. of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Participant, Parent or legal Guardian, signed in the presence of center staff)*



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## Participant’s Consent for Release of Information

I hereby authorize: \_\_\_\_\_ to release information  
(person or facility)

from the records of: \_\_\_\_\_ DOB: \_\_\_\_\_  
(participant’s name)

The information is to be released to: \_\_\_\_\_  
(FTGU or Director’s name)

for the purposes of developing an equine activity program for the above named participant. The information to be released is indicated below:

- Medical History
- Physical Therapy evaluation, assessment and program plan
- Occupational Therapy evaluation, assessment and program plan
- Speech Therapy evaluation, assessment and program plan
- Mental Health diagnosis and treatment plan
- Individual Habilitation Plan (I.H.P.)
- Classroom Individual Education Plan (I.E.P.)
- Psychosocial evaluation, assessment and program plan
- Cognitive-Behavioral Management Plan
- Other: \_\_\_\_\_

This release is valid for one year and can be revoked, in writing, at my request.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relation to Participant: \_\_\_\_\_

Please send materials to: **Andrea Colella, Program Director**  
**From the Ground Up Therapeutic Horsemanship, Inc.**  
**P.O. Box 323**  
**Jamesville, NY 13078**



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**Therapeutic Horsemanship, Inc.**

Date:

Dear Physician:

Your patient, \_\_\_\_\_ (participant’s name) is interested in participating in supervised equestrian activities.

In order to safely provide this service, From the Ground Up Therapeutic Horsemanship, Inc. requests that you complete the attached Medical History and Physician’s Statement Form. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

**Orthopedic**

Atlantoaxial Instability – including neurologic symptoms  
Coxa Arthrosis  
Cranial Deficits  
Heterotopic Ossification/Myositis Ossificans  
Joint subluxation/dislocation  
Osteoporosis  
Pathologic Fractures  
Spinal Fusion/Fixation  
Spinal Instability/Abnormalities

**Neurologic**

Hydrocephalus/Shunt  
Seizure  
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

**Other**

Age – under 4  
Indwelling Catheters  
Medications – i.e. photosensitivity  
Poor Endurance  
Skin Breakdown

**Medical/Psychological**

Allergies  
Animal Abuse  
Physical/Sexual/Emotional Abuse  
Blood Pressure Control  
Dangerous to self or others  
Exacerbations of medical conditions  
Fire Settings  
Heart Conditions  
Hemophilia  
Medical Instability  
Migraines  
PVD  
Respiratory Compromise  
Recent Surgeries  
Substance Abuse  
Thought Control Disorders  
Weight Control Disorders

Thank you very much for your assistance. Should you have any concerns or questions regarding your patient’s participation in therapeutic equine activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,

Andrea Colella  
Executive Director



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**Participant’s Medical History and Physician’s Statement**

Participant Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_  
 Past/Prospective Surgeries: \_\_\_\_\_  
 Medications: \_\_\_\_\_  
 Seizure Type: \_\_\_\_\_ Controlled: Y N Date of Last Seizure: \_\_\_\_\_  
 Shunt Present: Y N Date of Last Revision: \_\_\_\_\_  
 Special Precautions/Needs: \_\_\_\_\_

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: \_\_\_\_\_

*For those with Down Syndrome:* AtlantoDens Interval X-rays, date: \_\_\_\_\_ Result: + --

Neurologic Symptoms of AtlantoAxial Instability: \_\_\_\_\_

*Please indicate current or past special needs in the following systems/areas, including surgeries:*

|                         | Y | N | Comments |
|-------------------------|---|---|----------|
| Auditory                |   |   |          |
| Visual                  |   |   |          |
| Tactile Sensation       |   |   |          |
| Speech                  |   |   |          |
| Cardiac                 |   |   |          |
| Circulatory             |   |   |          |
| Integumentary/Skin      |   |   |          |
| Immunity                |   |   |          |
| Pulmonary               |   |   |          |
| Neurologic              |   |   |          |
| Muscular                |   |   |          |
| Balance                 |   |   |          |
| Orthopedic              |   |   |          |
| Allergies               |   |   |          |
| Learning Disability     |   |   |          |
| Cognitive               |   |   |          |
| Emotional/Psychological |   |   |          |
| Pain                    |   |   |          |
| Other                   |   |   |          |



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Given the above diagnosis and medical information, this person is not medically precluded from participating in equine assisted activities and/or therapies. I understand that the From the Ground Up Therapeutic Horsemanship, Inc. will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to From the Ground Up Therapeutic Horsemanship, Inc. for ongoing evaluation to determine eligibility for participation.

Name/Title: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: ( ) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_

**Authorization for Emergency Medical Treatment Form**  
*(for participant/rider)*

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Physician's Name: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Current medications: \_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

~~NON-CONSENT PLAN~~  
**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 the center, I authorize \_\_\_\_\_ to:  
 \_\_\_\_\_ (center's name)  
 Secure and retain medical treatment and transportation if needed.

Parent or legal guardian will remain on site at all times during equine assisted activities  
 In the event emergency treatment/aid is required, I wish the following procedure to take place:  
 Release participant records upon request to the authorized individual or agency involved in the  
 \_\_\_\_\_ medical emergency treatment.

This authorization includes X-rays, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_  
 \_\_\_\_\_ (Participant, Parent or Legal Guardian, signed in presence of center staff)  
 Date: \_\_\_\_\_ Non-Consent Signature: \_\_\_\_\_  
 \_\_\_\_\_ (Participant, Parent or Legal Guardian, signed in presence of center staff)

**Authorization for Emergency Medical Treatment Form**  
*(for parent/guardian volunteer)*



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Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Physician's Name: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Current medications: \_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>NON-CONSENT PLAN</b><br/> <b>CONSENT PLAN</b></p> <p>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 the center. In the event emergency medical treatment is required due to illness or injury during the process of receiving services, or while being on the property of the center, I authorize _____ to: _____<br/> <small>(center's name)</small></p> <p><input type="checkbox"/> 1. Parent or legal guardian will remain on site at all times during equine assisted activities. Secure and retain medical treatment and transportation if needed.</p> <p><input type="checkbox"/> 2. In the event emergency treatment/aid is required, I wish the following procedure to take place:<br/>       Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment.<br/>       _____</p> <p>This authorization includes X-rays, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.</p> <p>Date: _____ Consent Signature: _____<br/> <small>(Parent or Legal Guardian, signed in presence of center staff)</small></p> <p>Date: _____ Non-Consent Signature: _____<br/> <small>(Parent or Legal Guardian, signed in presence of center staff)</small></p> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**Release of Liability**

Witness this agreement this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ by and between From the Ground Up Therapeutic Horsemanship, Inc. hereinafter referred as MANAGER and \_\_\_\_\_, hereinafter referred to as RIDER. For the consideration received, and in return for the use, today and on all future dates of the property, facilities and services of MANAGER, RIDER, Rider's heirs, assigns, and representatives hereby agree as follow:



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1. **Inherent Risks and Assumption of Risk.** The undersigned acknowledges there are inherent risks associated with equine activities such as described below and hereby expressly assumes all risks associated with participating in such activities. The inherent risks include, but are not limited to the propensity of equines to behave in ways such as, running, bucking, biting, kicking, shying, stumbling, rearing, falling or stepping on, that may result in an injury, harm or death to persons on or around them; the unpredictability of equine reaction to such things as sounds, sudden movement and unfamiliar objects, persons or other animals; certain hazards such as surface and subsurface conditions; collisions with other animals; the limited availability of emergency medical care; and the potential of a participant to act in a negligent manner that may contribute to injury to the participant or others, such as failing to maintain control over the animal or not acting within the participant’s ability.

RIDER acknowledges that horses, by their very nature are unpredictable and subject to animal whim. RIDER assumes all risks in connection therewith, and expressly waives any claims for any injury or loss arising therefrom. RIDER agrees to abide by and follow MANAGER’s rules and regulations, which shall be posted and/or available from time to time. RIDER further acknowledges that the behavior of any animal is contingent to some extent upon the ability of the RIDER. Rider assumes all risks therefore and warrants a full and fair disclosure of RIDER’s abilities has been made to the MANAGER.

2. RIDER agrees to hold harmless, indemnify and defend MANAGER against, and hold harmless from, any and all claims, demands, causes of action, damages, judgments, orders, costs or expenses, including attorney’s fees, whether actually incurred or not, which may in any way arise from or be in any way connected with RIDER’s use of or presence upon the property of MANAGER and the facilities located thereon.

3. In the event RIDER is using RIDER’s own horse, or a horse(s) not owned by the MANAGER, RIDER warrants said horse(s) shall be free from infection, contagious or transmittable diseases, MANAGER reserves the right to refuse access or use of any horse upon the premises that does not appear to MANAGER to be in good health, or is deemed dangerous or undesirable.

4. RIDER agrees to waive the protection of any applicable statutes in this jurisdiction whose purpose, substance and/or effect is to provide that a general release shall not extend to claims, material or otherwise which the person giving that release does not know or suspect to exist at the time of executing said release.

\_\_\_\_\_  
MANAGER

\_\_\_\_\_  
RIDER

*If participant (RIDER) is under 18 years old, Parent or Guardian must sign:*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_