Hope on Horseback
Therapeutic Riding Center
7280 Sterrettania Rd.
Fairview, PA 16415
(814) 474-5276
program@hopehorseback.org

2019 **Office use only**
Date Received: Contacted by: Date: Comments: Physician Ref. Payment:

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RENEWAL APPLICATION, HEALTH INFORMATION AND RELEASE FORM

Please print neatly. Complete both sides of the form.

Rider's Name ____

Date of Birth __________________ Age _______

Height ___________ (feet and/or inches) Weight ________ Due to safety considerations, any applicant who weighs more than 180 pounds will need approval from the Program Director

Address ___________________________________ City___________ Zip ________

Phone ______________ Cell ______________ Email __________________________________

School/Employer ____

Parent/Legal Guardian if applicant is under 18 years of age __________________________________

Address (If different from above) ____

Phone & Email (if different from above) ____

Mother's Employer ____________________________ Occupation ___________________________

Father's Employer ____________________________ Occupation ___________________________

Emergency Contact (other than parent) ____

Relationship _______________________________ Phone ________________________________

Day/Time Preferences (Please list several choices)

____

Request for Scholarship application________

HEALTH INFORMATION

Diagnosis ____ Date of Onset ____________________

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

PHYSICAL FUNCTION (i.e. Mobility skills such as transfers, walking, wheelchair)

____

PSYCHO/SOCIAL FUNCTION (i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc)

____

____

GOALS Update (What would you like to accomplish? i.e. social skills, fine motor skills, ride independently)

____

____

HOHB CLIENT LIABILITY AND MEDICAL RELEASE

The undersigned, (as parent or guardian of ______________________________, where applicable or if client is under 18 years of age), in consideration of the instruction given in the horseback riding program furnished by Hope on Horseback Therapeutic Riding Center, does hereby release, discharge, and indemnify HOHB from all claims which the undersigned (or said minor) may have now or in the future resulting from personal injury, death, or property damage to the person or property, caused or in any way growing out of acts of HOHB. It is the understanding that HOHB and its personnel shall take all reasonable precautions regarding the operation of the riding program. I intend to be legally bound by this agreement.

Further, the undersigned authorizes any licensed physician and/or emergency medical personnel to provide any medical/surgical care and/or hospitalization for the client, including anesthetic, which they determine necessary or advisable, pending receipt of specific consent from the undersigned.

____ Date ______________

Applicant's Signature
(Or signature of parent or guardian where applicable, or if applicant is under 18 years of age.)

PHOTO/PUBLICITY RELEASE

I hereby ______________ Therapeutic Riding Equestrian Center permission to use my____________________
Give/ do not give **own/sons/ daughters**
Name or photographs in its public relations efforts for the primary purpose of promoting The Hope on Horseback Therapeutic Riding Center, and for soliciting financial support for HOHB.

____ Date ____________________

Applicant's Signature
(Or signature of parent or guardian where applicable, or if applicant is under 18 years of age.)

HOHB Program Director
7280 Sterrettania Rd.
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