LIABILITY & MEDICAL RELEASE FORM
GROUPS 2020

This form is to be completed and signed by the rider if over 18 years old, or by the rider's parent / guardian in the case of a minor

Client / rider information	
Name:	Date of birth:
Address:	City, postal code:
Home phone:	Cell phone:
Email:	

Risks inherent to the activity

I acknowledge the risks inherent to the horse and / or to any equestrian activities, regardless of the safety measures in place, and of the level of supervision from the staff as well as the level of skill and experience of the riders and the side walkers, including but not limited to:

- Physical injuries that can possibly lead to death, due to:
  - The unpredictable nature of the behavior of the horse (sudden halt, the change of direction, acceleration, bucking, backing up, biting, abrupt departure, etc.);
  - A participant, volunteer or staff member acting in a negligent manner, including but not limited to, failing to maintain control of the horse or failing to act with the required skills;
  - A food allergy;
  - Heatstroke;
- Injuries sustained from an object located in the center, such as equipment, the facility, etc.

I acknowledge having been informed on the risks inherent to my presence on the grounds of Enfants en Équi-Libre. I acknowledge that this list only represents a few of the possible risks and I agree to assume all other risks not mentioned above.

Photo & video consent

I consent to authorize the use and reproduction by Enfants en Équi-Libre of any and all photographs and any other audiovisual materials taken of me for promotional material, educational activities, exhibitions, or for any other use for the benefit of the program?

◯ YES / ◯ NO

(Client name) _____ would like to participate in a riding program / receive therapy services from Enfants en Équi-Libre. I acknowledge the risks, the potential for risk, of horseback riding. However, I feel that the possible benefits to myself / 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 Enfants en Équi-Libre, its instructors, therapists, aides, volunteers, and/or employees for any and all injuries and/or losses that I / my son / my daughter / my ward may sustain while participating in programming / receiving services from Enfants en Équi-Libre.

I certify that the information contained in this form is accurate to the best of my knowledge. I certify that I did not deliberately omit information about my health condition or the health condition of my child, relevant or not. I am aware that the information contained in this form is confidential and aims to better plan and supervise the safety of the activities in which I will participate.

Name of client *(please print)*: _____

Name of parent/guardian *(if applicable, please print)*: _____

Signature *(of the client or legal representative)*: _____ Date: _____

This form is to be completed and signed by a medical doctor in the case of a physical disability, or a health professional for all non-physical disabilities

Client / rider information	
Name:	Date of birth:

Medical information	
Primary diagnosis:	
Secondary diagnosis:	
Height:	Weight (max 160lbs):
Cerebral Palsy: ◯ YES / ◯ NO	If yes, please specify: Monoplegia, Diplegia, Quadriplegia, Hemiplegia (which side L / R)
Diabetic: ◯ YES / ◯ NO	Insulin: ◯ YES / ◯ NO
Ambulatory: ◯ YES / ◯ NO	If no, please indicate equipment used:
Medication: ◯ YES / ◯ NO	If yes, please specify:
Allergies: ◯ YES / ◯ NO If yes, please specify	Epipen: ◯ YES / ◯ NO

Other pertinent information	
Muscle tone in upper extremities (good / fair / poor):	
Muscle tone in lower extremities (good / fair / poor):	
Tone in trunk (good / fair / poor):	
Spasticity:	
Coordination:	
Balance:	
Language(s) spoken / understood:	
Speech (good / fair / poor):	Ability to understand (good / fair / poor):
Vision (good / fair / poor):	Hearing (good / fair / poor):
Sensory sensitivity:	
Communicable disease(s): ◯ YES / ◯ NO If yes, please specify:	
Surgical history & dates:	

Atlanto-axial x-ray verification
Due to the nature of this activity (horseback riding), Down Syndrome with an atlanto-axial instability is a contraindicated condition. A negative atlanto-axial instability x-ray is required. If the rider has Down Syndrome this form must be signed and dated by a qualified physician giving the date and result of the diagnostic X-ray. ◯ This client does not have Down Syndrome ◯ This client has Down Syndrome
Date of X-ray:
Result of X-ray:

Seizure policy
Due to the nature of this activity (horseback riding), participants with a seizure disorder will not be permitted to participate in mounted activities if they have had a seizure in the last 12 months (unmedicated), or 6 months (medicated). ◯ This client does not have a seizure disorder ◯ This client has a seizure disorder
If yes, please specify type and frequency of seizures:
Currently taking medication to control seizures: ◯ YES / ◯ NO
Date of last seizure:

The undersigned hereby acknowledges that _____ is medically able to participate in the equestrian program / receive services offered by Enfants en Équi-libre.

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic center will weigh the medical information above against existing therapeutic riding precautions and contraindications. Assessment of this person's abilities / limitations for the purpose of implementing an effective equestrian program is the responsibility of the center.

Note: In the case of a physical disability, this form must be signed by a medical doctor. For all non-physical disabilities, this form can be signed by an occupational therapist or physical therapist with good knowledge of the individual.

Physician / health professional's name & title: _____

Signature: _____ **Date:** _____

Physician / health professional's address: _____

Phone: _____ **Email:** _____