Session: _____
(to be completed by Free Rein)

P. O. Box 1325
Brevard, NC 28712
828-883-3375

RIDER'S REGISTRATION PACKET

For General Therapeutic Riding Classes

REGISTRATION (to be completed by parent/guardian):

STUDENT'S NAME:_____

ADDRESS:_____

CITY:_____STATE:_____ ZIP:_____

DATE OF BIRTH:_____ AGE:_____ GENDER: M F

HEIGHT:_____ WEIGHT:_____

DIAGNOSIS:_____

PARENT OR GUARDIAN:_____

HOME PHONE:_____ CELL PHONE:_____

EMAIL ADDRESS:_____

Guardian/Parent address/phone if different from above:

_____

_____

_____

Referral Source:_____

CONFIDENTIALITY POLICY

Free Rein Center for Therapeutic Riding and Education has a legal and ethical obligation to maintain confidentiality of the sensitive information it may receive about a rider.

General Principles: Riders and their families have a right to privacy that gives them control over the dissemination of their medical or other sensitive information. Free Rein shall preserve the right of confidentiality for all individuals in its program.

Information Covered By Confidentiality Policy: Information covered by this policy includes medical, financial, social, referral and personal (including last names) regarding a person and his/her family. This type of information is protected and volunteers or employees who receive this type of information will not disclose it to anyone else regardless of how it is obtained.

Persons Subject to the Confidentiality Policy: Anyone who works, volunteers for, or provides services to Free Rein is bound by this policy. This includes but is not limited to: full- and part-time staff, independent contractors, volunteers, temporary volunteers, and board members. This policy also applies to anyone connected with Free Rein who could obtain this information either accidentally or on purpose.

PHOTO RELEASE (check one):

I _____ DO

_____ DO NOT

hereby consent to and authorize the use and reproduction by Free Rein of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional material, educational activities or for any other use for the benefit of the program.

Date:_____ Signature:_____

Health History to be Completed by Parents/Guardians

Please indicate current or past problems in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensory			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognitive			
Sensitivities			
Allergies			

Describe student's difficulties/challenges in the following areas (including assistance required or equipment needed):

Functional (for example, mobility skills such as transfers, walking assistance, wheelchair use):

_____

_____

_____

Social (i.e., work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.):

_____

_____

_____

What are your goals for the student's participation at Free Rein? (i.e., why are you applying for participation. What would you like to accomplish?):

General: _____

_____

_____

Physical: _____

_____

_____

Social/Emotional: _____

_____

_____

Tell us anything additional that you think may help us in working with your child: (i.e., fears, behavior at school, sensitivities):

Consent for Release of Information
Authorization for Use or Disclosure of Protected Health Information

1. Authorization

   I authorize Free Rein Center for Therapeutic Riding and Education to use and disclose the protected information and record of:
   (Participants Name): _____ DOB: _____
   This information is released to:
   (Name of Individual/Center): _____

2. Effective Period
   This authorization for release of information covers the period of healthcare from: (please check one)

   a. □ _____ to _____

   OR

   b. □ All past, present and future periods.

3. Extent of Authorization
   _____ (Initial here) I authorize the release of my complete health record (including records relating to mental healthcare).

   OR

   □ Physical Therapist

Name: _____Phone: _____

   □ Occupational Therapist

Name: _____Phone: _____

   □ Speech Therapist

Name: _____Phone: _____

   □ Psychotherapist

Name: _____Phone: _____

   □ Classroom Teacher (s)

Name: _____Phone: _____

   □ Medical Doctor

Name: _____Phone: _____

Other: _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Client/Guardian (if client is under 18 years old)

_____

Date: _____

Signature of Free Rein Representative

_____

Date:_____

PARTICIPANT'S AUTHORIZATION FOR MEDICAL TREATMENT FORM

Name:_____ Date of Birth:_____

Address:_____

Home Phone:_____

Health Insurance Company:_____ Policy #:_____

Physician's Name:_____ Medical Facility:_____

Physician's Phone:_____

Diagnosis:_____

Allergies to medications:_____

Current medications, including over-the-counter medications:

_____

_____

In the event of emergency, contact:

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Free Rein Center for Therapeutic Riding and Education to:

1. Secure and retain medical treatment and transportation if needed and,
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

(CHOOSE ONE OF THE FOLLOWING)

*Consent Plan:

This authorization includes x-ray, 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.

Consent signature:_____ Date signed:_____
Client, Parent, or Legal Guardian

*Non-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 agency. In the event emergency treatment/aid is required, I wish the following to take place:

_____

_____

_____

Consent signature:_____ Date signed:_____
Client, Parent, or Legal Guardian