EQUINE EMPOWERMENT FOUNDATION

Appointments 805-669-6769 · EquineEmpowermentFoundation.org

New TCRC Rider Registration and Emergency Contact Information

Please complete every section. Print clearly if filling by hand. Return to Jasmine Ghent, Executive Director, at the appointments line 805-669-6769 or by email, or bring it to the first lesson.

Rider Information

Rider's full name | Date of birth | Age | Gender

Home address | City / ZIP

School / program | Grade | Home language | Rider's T-shirt size

Mother or Legal Guardian Information

Full name | Relationship to rider | Cell phone | Email

Address (if different from rider) | Employer / work phone

Father or Legal Guardian's Information

Full name | Relationship to rider | Cell phone | Email

Address (if different from rider) | Employer / work phone

Emergency Contact (someone other than a parent/guardian)

Full name | Relationship | Phone | Alternate phone

TCRC Service Coordinator Information

Service coordinator name | Phone | Email

Rider's UCI number | Authorization number | Authorized sessions per month | Authorization dates (from – to)

Health History

****Certain medical conditions or indicators under Health History may require a Medical Clearance by your Primary Care Physician or Specialist prior to participating in our programs.****

New TCRC Rider Registration (continued)

Primary diagnosis

Secondary diagnoses / conditions

Height

Weight

Primary care physician

Physician phone

Current medications and dosage schedule

Allergies (medications, food, environmental, animals / hay / dust)

Seizure disorder? If yes, note type, frequency and date of last seizure below.	☐ Yes	☐ No
Uses a wheelchair, walker, braces or other assistive device?	☐ Yes	☐ No
Any surgery in the past 12 months, or planned?	☐ Yes	☐ No
Hip, spine or neck concerns (including atlantoaxial instability / Down syndrome screening	☐ Yes	☐ No
Shunt, feeding tube, catheter or other implanted / indwelling device?	☐ Yes	☐ No
Difficulty with balance, sitting unsupported, or following one-step directions?	☐ Yes	☐ No
History of aggression toward people or animals, running / elopement, or self-injury?	☐ Yes	☐ No

Details for any 'Yes' above, plus sensory needs, communication style, and what helps your rider feel calm and safe

Rider's goals for the program (parent/guardian and, if possible, the rider's own words)

Previous riding or animal experience

Fears or triggers we should know about

NO CALL, NO SHOW POLICY

When you enroll at EQUINE EMPOWERMENT FOUNDATION, you are scheduled on a regular basis and a horse is prepared prior to each lesson. We also schedule staff and volunteers to meet the needs of the class (both in individual and group lessons).

New TCRC Rider Registration (continued)

LESSON RATES

30-Minute Private Lesson — $100. 45-Minute Private — $125. 50-Minute Group Lesson — $100.

All No Call / No Show absences will be charged the full lesson fee. After three (3) No Call / No Shows, you will be taken off the calendar.

If you wish to cancel your ride with us you must give us 24 hr prior notice or full payment will be charged. Everyone feels they have a valid reason for us to waive the cancellation fee when a ride is cancelled for social, family, health or business reasons, but there can be NO exceptions to the rule.

If you are more than 10 minutes late for your scheduled lesson you will NOT be able to ride. Please arrive on time. If you are consistently late we will need to discuss a different time that is more suitable.

For lessons cancelled with 24 hour prior notice, we allow for one make-up lesson a month.

Please understand that we are a start-up 501(c)(3) nonprofit and have not received significant funding or grants yet; every scheduled lesson is what pays the bills to support the horses and afford our instructors. We truly appreciate your understanding and support!

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND AGREE WITH EEF'S NC/NS POLICY.

Parent / Guardian — printed name

Parent / Guardian — signature

Date

General Information

How did you hear about EEF?

Preferred lesson days / times

Rider has participated in therapeutic riding before? (where / when)

Photo / video release for EEF website and social media? Yes / No

Billing Information

Lessons are paid by:

☐ TCRC (Regional Center authorization) ☐ Private pay ☐ Other / split (explain below)

Name responsible for billing

Phone

Email

Billing address

Private-pay method (check, Zelle, card)

Notes (sibling discounts, scholarships, other funding)

Release of Liability

I acknowledge that horseback riding, barn activities, and other equine activities involve inherent risks, including the risk of serious injury or death. I freely and voluntarily assume those risks and, to the fullest extent permitted by law, release and hold harmless Equine Empowerment Foundation, TCRC, and their staff, volunteers, and affiliates from any liability arising from my or my child's participation. I confirm that the health information above is complete and accurate, that I will notify EEF of any change, and that I will provide a physician's clearance if EEF requests one. I authorize EEF staff to obtain emergency medical treatment for the rider if a parent or guardian cannot be reached.

New TCRC Rider Registration (continued)

Parent / Guardian — printed name	Parent / Guardian — signature	Date

Rider's name (printed)	Rider's signature (if 18 or older)	Date

Office use: date received _____ reviewed by _____ physician clearance needed? Y / N first lesson _____

Physician's Clearance & Orders

CONFIDENTIAL MEDICAL INFORMATION — TO BE COMPLETED BY LICENSED PHYSICIAN ONLY

Dear Physician: Your patient is seeking participation in equine-assisted activities and adaptive riding at Equine Empowerment Foundation. Equine movement provides dynamic neuromuscular, sensory, and vestibular stimulation. To ensure participant safety and proper program tailoring, please complete the medical evaluation below, indicating any known conditions, precautions, or contraindications. This form may be typed in any PDF viewer or completed by hand; return it to the family or fax/email it to EEF.

1. Participant Demographics

Participant name	Date of birth	Gender	Height / weight

Primary diagnosis	Date of onset	Mobility / assistive devices	Past / prospective surgeries

2. Critical Precaution & Contraindication Screening

Please mark if any of the following conditions are present, and indicate severity, precautions, or degree of involvement.

Clinical category	Specific condition / finding	Yes	No	Physician notes / precautions
Orthopedic & Spinal	Atlantoaxial instability (AAI) / cervical subluxation — include neurologic exam / imaging status if Trisomy 21	☐	☐	
Orthopedic & Spinal	Coxa arthrosis / hip subluxation / dislocation	☐	☐	
Orthopedic & Spinal	Cranial deficits / structural bone abnormalities	☐	☐	
Orthopedic & Spinal	Heterotopic ossification / myositis ossificans	☐	☐	
Orthopedic & Spinal	Osteoporosis / pathologic fractures	☐	☐	
Orthopedic & Spinal	Spinal fusion / internal fixation / spinal instability	☐	☐	
Neurologic	Hydrocephalus / indwelling shunt (type)	☐	☐	
Neurologic	Seizure disorder (type, frequency, date of last seizure)	☐	☐	
Neurologic	Spina bifida / tethered cord / hydromyelia	☐	☐	
Medical & Vascular	Severe hypertension / cardiovascular instability	☐	☐	
Medical & Vascular	Peripheral vascular disease (PVD) / DVT risk	☐	☐	
Medical & Vascular	Respiratory compromise / post-surgical limitations	☐	☐	
Medical & Devices	Indwelling catheters / stomas / skin breakdown	☐	☐	
Behavioral & Psych	Substance abuse / thought disorder / active psychosis	☐	☐	
Behavioral & Psych	History of animal harm / aggression toward others	☐	☐	

3. Comprehensive Systems Review

Indicate current or past difficulties, functional deficits, or surgical interventions in the systems below. Check WNL if within normal limits.

Physician's Clearance & Orders (continued)

Functional system	WNL	Deficit	Physician notes / precautions
Auditory / hearing	☐	☐	
Visual / ophthalmic	☐	☐	
Tactile / sensory processing	☐	☐	
Speech & expressive communication	☐	☐	
Cardiac & circulatory	☐	☐	
Integumentary / skin breakdown risk	☐	☐	
Immunity / infection risk	☐	☐	
Pulmonary / respiratory	☐	☐	
Neurologic & vestibular function	☐	☐	
Musculoskeletal / tone / range of motion	☐	☐	
Postural control & static/dynamic balance	☐	☐	
Orthopedic / spinal alignment	☐	☐	
Allergies (medications, environmental, equine)	☐	☐	
Cognitive / learning profile / executive function	☐	☐	
Emotional regulation / behavioral profile	☐	☐	
Chronic pain (location, triggers, management)	☐	☐	
Other / general medical	☐	☐	

In section 3, check the first box for WNL / no concern and the second box if there is a deficit or history; describe it in the notes field.

4. Physician's Prescription & Medical Clearance Statement

Prescription / clearance statement

Recommended program frequency (1x/week, 2x/week, other)

Specific precautions / movement restrictions

Current medications & dosage schedule

Emergency / rescue protocol (if applicable)

Physician's Clearance & Orders (continued)

Physician Clearance Attestation: To the best of my knowledge, there is no medical contraindication to this individual's participation in supervised equine-assisted activities and adaptive riding. I understand that the equine professional and therapy team will weigh the clinical information provided against existing precautions and PATH/program standards. I concur with a review of this person's abilities and limitations by licensed professionals and certified instructors in the implementation of an effective equestrian plan.

Physician name (printed)	Physician signature	Date

Clinic / practice name	Phone / contact	NPI / state license #