



## STUDENT REGISTRATION FORM

Please fill out all requested information.

Student Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

School/Occupation: \_\_\_\_\_ Current Grade: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Is the student his/her own legal guardian? Y N If NO, please provide the following information:

Name of parent(s)/guardian(s): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Contact Information: How can Lovesome reach you in a non-emergency - ie: to discuss scheduling?

Home#: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_

Email address(es): Please only list email addresses that you want to be used.

Personal: \_\_\_\_\_ Work: \_\_\_\_\_

Please describe the student's primary diagnosis: \_\_\_\_\_

Are there any specific strategies that could be used to enhance this student's camp experience?

\_\_\_\_\_

What do you, as a student or parent, hope to gain from this camp experience?

\_\_\_\_\_

Camp Session Dates: \_\_\_\_\_

Shirt Size: \_\_\_\_\_

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

Lovesome Stables Inc. is not equipped to take clients that have severe behavioral and/or medical issues resulting in intensive supervision or care. Medicines may not be administered on site by Lovesome staff. A licensed health professional may administer medication only designated by the students' primary caretaker. Any violent/aggressive/threatening behavior to other students, staff, volunteers or animals cannot be tolerated and will be grounds for removal from the program.

**MEDICAL INFORMATION FORM**

Participant's name: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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

Past/Upcoming Surgeries: \_\_\_\_\_

Medications: \_\_\_\_\_

Seizure Activity: Y N Seizure Type: \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

Shunt Present: Y N Date of last revision: \_\_\_\_\_

Special Precautions/Needs: \_\_\_\_\_

Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N Braces: \_\_\_\_\_

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

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

Please indicate present or past difficulties 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			

In my opinion, this patient can participate in supervised equestrian/summer camp activities. I understand that Lovesome Stables, inc. will weigh the medical information provided against the existing precautions and contraindications of therapeutic horseback riding. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc) in the implementation of an effective equestrian program.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's name (please print or stamp): \_\_\_\_\_

Address/City/Zip: \_\_\_\_\_



## Authorization for Emergency Medical Treatment Form

Please fill out all requested information.

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

In case of emergency, please contact:

Name/Relationship	Home Phone	Cell Phone	Work Phone
_____	_____	_____	_____
_____	_____	_____	_____

In the event of an emergency and the emergency contact(s) cannot be reached, please initial **one** of the following plans and complete the information requested:

\_\_\_\_\_ **Consent Plan**

In the event of an emergency and the emergency contact(s) cannot be reached, I authorize Lovesome Stables, Inc. to make health care decisions with respect to the student named above.

Date: \_\_\_\_\_ Signature (Student, Parent or Guardian): \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

\_\_\_\_\_ **Non-Consent Plan**

I do **not** consent to Lovesome Stables, Inc. making health care decisions with respect to the student named above. If the Undersigned does **not** desire to grant Lovesome Stables, Inc. authority to make health care decisions for the student and if the Undersigned is not available, please state the procedures to be followed if the student is in need of medical attention due to illness or accident:

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Signature (Student, Parent or Guardian): \_\_\_\_\_

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

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_



## PHOTO RELEASE, CONFIDENTIALITY POLICY & STUDENT RELEASE FORM

Name of Student: \_\_\_\_\_

**PHOTO RELEASE:** I consent to and authorize the use and reproduction by Lovesome Stables, Inc. of any and all photographs and any other audio-visual materials taken of this student for promotional material, educational activities, and exhibits or for any other use for the benefit of Lovesome Stables, Inc.

Date: \_\_\_\_\_ Signature (Student, Parent or Guardian): \_\_\_\_\_

**CONFIDENTIALITY POLICY:** For the effectiveness and safety of the equestrian program, I understand that information pertaining to the student's medical condition(s) is shared with volunteers on a need-to-know basis. All information remains confidential. I agree with and support this policy.

Date: \_\_\_\_\_ Signature (Student, Parent or Guardian): \_\_\_\_\_

**CONSENT & WAIVER:** WARNING – Under Kentucky law, a farm animal activity sponsor, farm animal professional or other person does not have the duty to eliminate all risks of injury of participation in farm animal activities. There are inherent risks of injury that you voluntarily accept if you participate in farm animal activities.

I hereby request that the participant named above be accepted into the riding program operated by Lovesome Stables, Inc. I acknowledge that Lovesome Stables, Inc. has fully explained to me the scope of the riding program, including the potential for serious injury which can occur from riding, caring for and being around horses and farms.

Because of the potential benefits of Lovesome Stables, Inc.'s equestrian/summer camp programs, I agree to waive any claim which the above named participant or anyone accompanying the participant may have against Lovesome Stables, Inc., its employees and volunteers, Gatewood Arena, Inc., and arena owners, Paula and Duane Gatewood, and to release them from any liability or responsibility for accident, damage, injury or illness caused to the Undersigned or to any family member or guest accompanying the Undersigned on the premises, including, but not limited to, those caused by horses or physical conditions of this farm.

Date: \_\_\_\_\_ Signature (Student, Parent or Guardian): \_\_\_\_\_



## ALLERGY INFORMATION & TREATMENT

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please check one:

\_\_\_\_\_ No known allergies                      \_\_\_\_\_ Has known allergies

If there are known allergies, please complete the following section for each type of allergy. Please note below if an epipen is needed and its location.

**Allergic to:** \_\_\_\_\_

Reaction: \_\_\_\_\_

Treatment: \_\_\_\_\_

Call 911 if: \_\_\_\_\_

**Allergic to:** \_\_\_\_\_

Reaction: \_\_\_\_\_

Treatment: \_\_\_\_\_

Call 911 if: \_\_\_\_\_

**Allergic to:** \_\_\_\_\_

Reaction: \_\_\_\_\_

Treatment: \_\_\_\_\_

Call 911 if: \_\_\_\_\_

Please note location of **epipen** during lessons - \_\_\_\_\_

Form completed by: \_\_\_\_\_ Relationship: \_\_\_\_\_