Starbrite Therapeutic Equestrian Center Registration Form

Participant Name:_____Phone: _____

Address:_____Email:_____

_____

DOB:_____Age:_____Height:_____Weight:_____ Gender: M F

Diagnosis(es):_____

_____

Participant's occupation/school grade level:_____

Important Information you would like to share:_____

_____

Specific Questions: _____

_____

Names of parents/guardian:

Guardian Name:_____Cell:_____

Father:_____Cell:_____

Mother:_____Cell:_____

Emergency Contact #1: Name:_____Cell:_____

Emergency Contact #2: Name:_____Cell:_____

Availability for the STARBRITE THERAPEUTIC EQUESTRIAN CENTER Program

(Check all available times and days)

☐ Monday AM	☐ Tuesday AM	☐ Wednesday AM	☐ Thursday AM	☐ Friday AM
☐ Monday PM	☐ Tuesday PM	☐ Wednesday PM	☐ Thursday PM	☐ Friday PM

Please List Any Specific Day/Time Conflicts:_____

_____

Starbrite Participant Tuition Form

Participant Name: _____

Grant and scholarship funds are available to cover rider tuition fees either partially or completely. Please help us understand your need for supplemental fee assistance. It is our goal to serve ALL families, regardless of income level.

The full rate for a lesson is $65/each. Please indicate your need below:

- ☐ I can pay the full rate
- ☐ I will need a partial scholarship or grant.
- ☐ I will need a full scholarship or grant.

Names of primary billing contact:

Name:_____ Phone: _____

E-mail address:_____

I understand and agree that all paperwork must be updated on an annual basis, including need-based scholarship information. Contact admin@starbritetyler.org or call (903)530-4050 for further information.

Signature of Participant or Legal Guardian_____Date_____

Starbrite Therapeutic Equestrian Center

Participant Liability Release and Confidentiality Agreement

Participant Name:_____ Date: _____

Parent/Legal Guardian:_____

Liability Release: Starbrite, its officers, members, employees, and agents (including volunteers) will not be responsible for any damages to person, animal or property at the Starbrite Therapeutic Equestrian Center or its grounds, nor will they be responsible for any property lost or destroyed. The undersigned Client or parent/guardian hereby releases Starbrite, its officers, members, employees, and agents from any and all liability and claims of any nature whatsoever, **including taking action to control, restrain, or confine the undersigned, for the safety or protection of the undersigned or others** and any damages whatsoever (including costs, expenses, and attorney's fees) that might result from damages, injuries, or losses to their person or property during, or in connection with, or arising out of, any class, lesson, demonstration, show, clinic, event or other function, **WHETH-ER OR NOT SUCH DAMAGES, INJURIES, OR LOSSES RESULT DIRECTLY OR INDIRECTLY FROM THE NEGLIGENT ACT OR OMISSION OR OF ANY INTENTIONAL OR WILLFUL ACT OR TORT OF SUCH RELEASED PARTIES OR OF ANY INVITEE OF ANY RELEASED PARTY.** WARNING: UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTICE AND REMEDIES CODE), AN EQUINE PROFESSIONAL IS NOT LIABLE FOR ANY INJURY TO, OR THE DEATH OF, A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE
ACTIVITIES. In exchange for the use of property owned by Starbrite and other valuable consideration, I agree that my use of premises and any animals, facilities, or equipment owned by Starbrite is at my own risk. I further agree to indemnify and hold harmless Starbrite, and its respective officers, members, employees, and agents, from any and all suits, actions or claims of any type arising from my use of the premises or participation in an equine activity, or of such use or participation by my guest, whether or not such claims result directly or indirectly from the negligent act or omissions of the indemnified parties or otherwise.

Date_____ Signature_____
(Participant, Parent or Guardian)

Confidentiality Agreement:

I understand that all the personal information (written and verbal) about participants at ***STARBRITE THERAPEUTIC EQUESTRIAN CENTER*** is confidential and not to be shared with anyone without expressed written consent of the participant and their parent/guardian.

Date_____ Signature_____
(Participant, Parent or Guardian)

PHOTO/VIDEO SOCIAL MEDIA RELEASE FORM

I hereby grant Tyler Achievement Center for Kids dba Starbrite Therapeutic Equestrian Center ("Starbrite") permission to use my likeness in a photograph, video, or other digital media ("photo") for any social media marketing without payment or other consideration. This includes Instagram, Facebook, TikTok, and any other social media accounts used by Starbrite.

I understand and agree that all photos will become the property of the Starbrite and will not be returned.

I hereby irrevocably authorize Starbrite to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photo, unless otherwise agreed upon in writing by both parties.

I hereby hold harmless, release, and forever discharge Starbrite from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I HAVE READ AND UNDERSTAND THE ABOVE PHOTO RELEASE. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE OR UNABLE TO SIGN, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENTS/GUARDIANS AS EVIDENCED BY THEIR SIGNATURES BELOW.

I ACCEPT:

_____ _____

Name Date

_____

Signature

Weather/No Show/Discharge Policy

Sessions may be canceled or adjusted on a case-by-case basis at the discretion of the CEO, or Program Director when any of the following conditions are present:

- "RealFeel" is less than 34 degrees/more than 102 degrees, or at the discretion of the instructor on a case-by-case basis.
- If lightning is present 10 miles or less away
- Heavy precipitation
- Steady winds over 15mph; gusts over 25mph
- Unrideable arena or facility conditions
- Starbrite will follow Whitehouse ISD severe weather

A staff member will use your preferred method of contact to inform you of session cancellations directly. You may also call the office line at (903) 530-4050 to check on weather cancellations.

Discharge from the program may occur for reasons included but not limited to those listed below:

1. When participant riding presents a safety concern or hazard.
2. Inability to follow directions interferes with progress toward goals.
3. Inappropriate behavior or conduct that constitutes a risk to the participant, staff, horse, volunteer or Starbrite as an organization.
4. Participant exceeds weight limit, or otherwise presents a physical barrier to participation in the program.
5. Any change in the participant's medical, physical, cognitive, or emotional condition that makes therapeutic riding inappropriate.

I understand and agree with the cancellation and/or discharge policies above.

Date_____Signature_____

(Participant, Parent or Guardian)

Participant Goal Sheet

Participant name: _____

Personal riding goals: _____

Physical goals: _____

Cognitive goals: _____

Social goals: _____

Emotional/Behavioral: _____

Long Term goals: _____

Initial:_____Date:_____

Annual Participant Health History
For Physician

Participant Name: _____ DOB: _____ Height:_____

Weight_____

Diagnosis(es):_____ Approx. date of onset:_____

Recent surgeries:_____

Upcoming surgeries:_____

Current medications:_____

Seizures: Y/N Type:_____ Controlled: Y/N Date of Last Seizure:_____

Shunts/Implants/Appliances:_____

Mobility: Independent ambulation: Y/N Assisted ambulation: Y/N Wheelchair: Y/N

Communication: Verbal: Y/N Non-verbal: Y/N Other form of communication: _____

Neurologic symptoms of Atlanto-Axial Instability: Y/N

Please indicate and comment on any areas that require consideration below:

Area	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological/Sensation			
Bowel/Bladder			
Muscular			
Orthopedic			
Allergies			
Behavior			
Cognition			
Emotional/Psychological			
Other			

Starbrite Therapeutic Equestrian Center

For Physician

If the following conditions are present, please indicate severity and level of involvement.

Type	Present	Notes
Spinal Fusion		
Spinal Instabilities/Abnormalities		
Atlantoaxial Instabilities		
Scoliosis		
Kyphosis		
Lordosis		
Subluxation and Dislocation		
Osteoporosis		
Pathological Fractures		
Coxas Arthrosis		
Heterotopic Ossification		
Cranial Deficits		
Spinal Orthoses		
Internal Spinal Stabilization Devices		
Hydrocephalus/shunt		
Spina Bifida		
Chiari II Malformation		
Hydromyelia		
Paralysis due to Spinal Cord Injury		
Seizure Disorders		
Stroke (Cerebrovascular Accident)		
Peripheral Vascular Disease		
Varicose Veins		
Hemophilia		
Hypertension		
Serious Heart Condition		
Allergies		
Cancer		
Poor Endurance		
Recent Surgery		
Diabetes		
Poor Endurance		
Behavior Problems		
Tethered Cord		
Indwelling Catheter		
Chronic Disorder		

Physician's Signature:_____ Date:_____

Starbrite Therapeutic Equestrian Center Physician Release

For Physician

Participant name: _____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that ***STARBRITE THERAPEUTIC EQUESTRIAN CENTER*** will weigh the medical information contained in the physician release form against existing PATH Intl. precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Therapist, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician name: _____
Signature: _____Date:_____

Physician's name, address, and telephone number: **(please print, type or stamp):**

Medical Clearance report for Neurologic Symptoms of Atlanto-Axial Exam <u>For All Participants with Down syndrome:</u>

_____has undergone a neurological exam by a licensed physician to test for symptoms consistent with atlantoaxial instability. _____has been given medical clearance by the licensed physician below, due to the results of the neurological exam that denies any symptoms consistent with atlantoaxial instability.

Physician name: _____
Signature: _____Date:_____

Physician's name, address, and telephone number: **(please print, type or stamp):**
