

Corral

Coweta Organization for Riding, Rehabilitation And Learning

REGISTRATION AND RELEASE FORM

REGISTRATION

CLIENT _____ DATE OF BIRTH _____ AGE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ EMER PHONE _____

PARENTS/GUARDIAN _____

ADDRESS/PHONE _____

DIAGNOSIS _____

HEIGHT _____ WEIGHT _____ EMAIL _____

LIABILITY RELEASE

_____ would like to participate in the CORRAL program. I acknowledge the risks and potential for risks 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 CORRAL, its board of directors, instructors, therapists, aides, volunteers and/or employees for any and all injuries and/or losses I/ my son/my daughter/ my ward may sustain while participating in CORRAL.

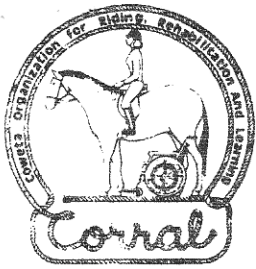
WARNING – Under Georgia law, an equine activity sponsor or equine professional is not liable for an injury to or the death resulting from the inherent risks of equine activities pursuant to Chapter 12 of Title 4 of the official code of Georgia Annotated.

Signature _____ Date _____

PHOTO RELEASE: Optional

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

Signature _____ Date _____



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Name _____ Date of Birth _____

Address _____

Name of Parent/Guardian _____

Diagnosis _____ Date of Onset _____

Tetanus Shot: Yes ___ No ___ Date _____ Height _____ Weight _____

Seizure Type _____ Controlled _____ Date of Last Seizure _____

Medications _____

**FOR PERSONS WITH DOWN SYNDROME

Cervical X-ray for Atlantoaxial Instability: Positive ___ Negative ___ X-ray Date _____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment, using back of form if necessary.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation Yes ☐ No ☐ Crutches Yes ☐ No ☐ Braces Yes ☐ No ☐ Wheelchair Yes ☐ No ☐

Please indicate any special precautions _____

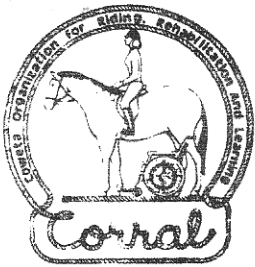
In my opinion this patient can participate in supervised equestrian activities. In conjunction with these activities I concur in the referral of the patient to a physical/occupational therapist or other health care professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program.

Physician Name (Please Print) _____

Physician Signature _____

Address _____ City _____ State _____ Zip _____

Phone (____) _____ Date _____



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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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 CORRAL to:

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

Client's Name _____ Phone _____
Address _____
In the event I cannot be reached, Contact _____ Phone _____
Contact _____ Phone _____
Physician's Name _____ Phone _____
Preferred Medical Facility _____
Health Insurance Co. _____ Policy # _____

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 listed below is unable to be reached.

Consent Signature _____ Date _____
Client, Parent or Guardian

Print Name _____ Phone _____
Address _____

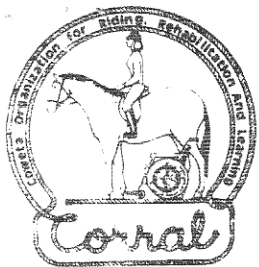
NON-CONSENT PLAN

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 procedures to take place:

Consent Signature _____ Date _____
Client, Parent or Guardian

Print Name _____ Phone _____
Address _____

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM.



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We are looking forward to having you or your child participating in our program. However, we may reach a point where we may no longer be able to safely provide our services to you or your child.

Safety is our top priority at CORRAL - the safety of the rider, the safety of the volunteers and the safety of the horse. If, at any time, we feel like the situation is unsafe, we reserve the right to end the student's participation in our program. This would include any behavior issues, as well as any student who does not meet NARHA's standards stating that a rider, including tack, pad, etc., may not exceed 20% of the horse's weight.

A certified instructor rides with the student when tandem riding (back riding). It is the sole discretion of the instructor to end the student's participation in our program if they feel the safety of the student, instructor, volunteer or horse is compromised.

Print Name

Date

Signature



CORRAL is partially funded by United Way. As a United Way organization we are required to obtain the following information for each client:

Please circle one from each category

Gender	Male	Female
Race/Ethnicity	African American	White
	Asian	Hispanic
Age	Under 5 yrs	26 - 36 yrs
	5 - 11 yrs	37 - 46 yrs
	12 - 17 yrs	47 - 59 yrs
	18 - 25 yrs	60 plus yrs

Income level

(as shown on chart)

Example:

If there are 3 people in your family and your income is above \$18,530 circle "above".

If there are 3 people in your family and your income is below \$18,530 circle "below".

# in Family/Household	Income			
1	\$10,890		Above	Below
2	\$14,710		Above	Below
3	\$18,530		Above	Below
4	\$22,350		Above	Below
5	\$26,170		Above	Below
6	\$29,990		Above	Below
7	\$33,810		Above	Below
8	\$37,630		Above	Below
Add for each additional person	\$3,820			

County of Residence	Coweta	Fayette
	Fulton	Other - please list

If you have any questions call CORRAL at 770-254-0840.