Coweta Organization for Riding, Rehabilitation And Learning

REGISTRATION AND RELEASE FORM

REGISTRATION

CLIENT _____ DATE OF BIRTH_____ AGE _____

ADDRESS _____ CITY _____STATE _____ ZIP _____

HOME PHONE_____ CELL 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 _____

52 Oliver Potts Road, Newnan, Georgia 30263 — (770) 254-0840
www.corraltrc.org

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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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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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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 PATH'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

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CORRAL receives grants from organizations that require us to provide the information below. Please fill out accordingly.

Please circle one from each category

Gender	Male	Female	
Race/Ethnicity	African American	White	Other
	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 yearly income is above $20,160 circle "above."
If there are 3 people in your family and your yearly income is below $20,160 circle "below."

# in Family/Household	Income			
1	$12,760		Above	Below
2	$17,240		Above	Below
3	$21,720		Above	Below
4	$26,200		Above	Below
5	$30,680		Above	Below
6	$35,160		Above	Below
7	$39,640		Above	Below
8	$44,120		Above	Below
Add for each additional person	$4,480			

Has any member of your immediate family (parents, grandparents, siblings) served in the United States military?

Yes	No

County of Residence	Coweta	Fayette
	Fulton	Other - please list

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

Jan-20

Covid-19 Acknowledgement of Risk and Acceptance of Services

I, _____ (Client Name), am aware of the risks of contracting Covid-19 while receiving face-to-face services from CORRAL at this time of the pandemic outbreak.

I am aware that face-to-face services increase my risk of contracting and passing on Covid-19 or Coronavirus and agree to hold harmless CORRAL, and all individuals I may come in contact with during this interaction and receiving of services.

I agree to and will follow all guidelines for personal hygiene, personal safety and public safety as recommended by CORRAL and my doctor. This may include, but is not limited to, waiting in my vehicle until I am asked to enter the building; use of hand sanitizer before beginning each session, and wearing a protective mask.

I agree to cancel my services should I have within the previous 24 hours to 2 weeks personally exhibited or have been in contact with someone who has presented with illness including; cough, sneezing, fever, chest congestion or additional signs of potential spread of any virus or bacteria/disease. In addition, I will follow the recommendations of my doctor once I have notified them of these risks in regards to my future services during this pandemic.

CORRAL will engage in regular cleaning and sanitizing of horse tack for the safety of clients, employees, volunteers, and horses.

I am signing under my own free will and choice and agree to follow these and hold harmless all individuals associated with or through my services acquired from CORRAL.

Client Name: _____ Date: _____

Client Signature: _____

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____