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 _____

52 Oliver Potts Road, Newnan, Georgia 30263 — (770) 254-0840

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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

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United Way
in Coweta & Fayette Counties

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 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 income is above $33,200 circle "above".
If there are 3 people in your family and your income is below $33,200 circle "below".

# in Family/Household	Income		
1	$10,210	Above	Below
2	$13,690	Above	Below
3	$17,170	Above	Below
4	$20,650	Above	Below
5	$24,130	Above	Below
6	$27,610	Above	Below
7	$31,090	Above	Below
8	$34,570	Above	Below
Add for each additional person	$3,480		

County of Residence Coweta Fayette

Fulton Other

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