



RIDER'S REGISTRATION AND RELEASE FORM

CHAMPLAIN ADAPTIVE MOUNTED PROGRAM
A volunteer, non-profit tax-exempt corporation

57 East Shore Road
South Hero, VT 05486
802-372-4087
www.vtchamp.org

REGISTRATION

RIDER DATE OF BIRTH AGE

ADDRESS

CITY/ STATE/ ZIP:

HOME PHONE: WORK PHONE:

EMPLOYER

SCHOOL OR INSTITUTION PRESENTLY ATTENDING:

NAME OF PARENT/GUARDIAN/CAREGIVER:

ADDRESS:

CITY/STATE/ ZIP:

HOME PHONE: WORK PHONE:

HOW DID YOU HEAR ABOUT CHAMP

REFERRAL SOURCE PHONE

WHAT ARE YOUR GOALS IN JOINING THIS PROGRAM

LIABILITY RELEASE

RIDER'S NAME: _____ would like to participate in the Champlain Adaptive Mounted 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 risks 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 the Champlain Adaptive Mounted Program - CHAMP at Good Hope Farm, its board of directors, instructors, therapists, volunteers and/or employees; and the North American Riding for the Handicapped Association; for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in CHAMP's activities. I also understand that under Vermont Law, an equine activity sponsor is not liable for an injury to, or the death of a participant in equine activities resulting from the inherent risks of equine activities that are obvious and necessary, pursuant to 12 V.S.A. 1039

SIGNATURE DATE

PRINT NAME BELOW IF SIGNATURE IS BY A PARENT OR GUARDIAN (FOR RIDERS UNDER 18)

RELATIONSHIP



NARHA
North American Riding for the Handicapped Association, Inc.
PREMIER ACCREDITED CENTER

All CHAMP instructors are NARHA certified

A member agency of the Franklin-Grand Isle United Way.





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RIDER'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

MUST BE COMPLETED ANNUALLY

RIDER _____ DATE OF BIRTH _____ AGE _____

ADDRESS _____

CITY/ STATE/ ZIP _____

NAME OF PARENT/GUARDIAN _____

DIAGNOSIS _____ DATE OF ONSET _____

****FOR PERSONS WITH DOWN SYNDROME**

NEGATIVE CERVICAL X-RAY FOR ATLANTOAXIAL INSTABILITY. X-RAY DATE _____

NEGATIVE FOR CLINICAL SYMPTOMS OF ATLANTOAXIAL INSTABILITY.

SEIZURE TYPE MILD MODERATE SEVERE CONTROLLED? YES NO

RELEVANT NOTES: _____ DATE OF LAST SEIZURE _____

TETANUS SHOT: NO YES DATE _____ HEIGHT _____ WEIGHT _____

MEDICATIONS(PRESCRIBED & OTC) _____

PHYSICAL FUNCTION/MOBILITY: INDEPENDENT AMBULATION YES NO

CRUTCHES YES NO BRACES YES NO WHEELCHAIR YES NO

PLEASE NOTE ANY SPECIAL NEEDS OR PRECAUTIONS _____

PLEASE NOTE ANY PSYCHO/SOCIAL NEEDS _____

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. (See reference list on page 4)

AREAS	YES	NO	COMMENTS
AUDITORY			
VISUAL			
SPEECH			
CARDIAC			
CIRCULATORY			
PULMONARY			
NEUROLOGICAL			
MUSCULAR			
ORTHOPEDIC			
ALLERGIES			
LEARNING DISABILITY			
COGNITIVE IMPAIRMENT			
PSYCHOLOGICAL IMPAIRMENT			
OTHER			



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PHYSICIANS NOTE: The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore when completing this form, please note whether these conditions are present, and to what degree. **Circle the relevant conditions for this rider.**

Orthopedic

- Atlantoaxial Instabilities - includes neurologic symptoms
- Coxas Arthrosis
- Cranial Deficits
- Heterotopic Ossification/ Myositis Ossifications
- Osteoporosis
- Pathologic Fractures
- Spinal Joint Fusion/Fixation
- Spinal Joint Instabilities/ Abnormalities

Neurologic

- Hydrocephalus/shunt
- Sensory Deficit
- Seizure
- Spina Bifida/Chiari II Malformation/ Tethered Cord/Hydromyelia

Other

- Age under four years
- Indwelling Catheters/Medical Equipment
- Medications -i.e. photosensitivity
- Poor Endurance
- Skin Breakdown

Medical/Psychological

- Allergies
- Animal Abuse
- Cardiac Condition
- Physical/Sexual/Emotional Abuse
- Blood Pressure Control
- Dangerous to self or others
- Exacerbations of medical conditions (i.e. RA, MS)
- Fire Settings
- Hemophilia
- Medical Instability
- Migrains
- PVD
- Respiratory Compromise
- Recent Surgeries
- Substance Abuse
- Thought Control Disorders
- Weight Control Disorder



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Rider **Authorization for Emergency Medical Treatment**

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RIDER'S NAME	DOB	
ADDRESS		
CITY/STATE/ZIP		
PHONE: (H) _____	(W) _____	E-MAIL: _____
PHYSICIAN'S NAME		PREFERRED MEDICAL FACILITY
HEALTH INSURANCE CO.		POLICY #
IN CASE OF EMERGENCY CONTACT		
NAME	Relation	Phone
NAME	Relation	Phone
NAME	Relation	Phone

These forms must be signed in the presence of a member of the CHAMP Staff.

CONSENT PLAN: In the event emergency medical aid/treatment is required due to illness or injury during the process of therapeutic riding services provided by the Champlain Adaptive Mounted Program (CHAMP), or while on the property I authorize CHAMP at Good Hope Farm to:

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

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(s) above is unable to be reached.

SIGNATURE	DATE
PRINT NAME BELOW IF SIGNATURE ABOVE IS BY A PARENT OR GUARDIAN FOR A VOLUNTEER UNDER 18	
RELATIONSHIP	

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 therapeutic riding services provided by the Champlain Adaptive Mounted Program (CHAMP), or while on the property.

- Parent or legal guardian will remain on site at all times during equine assisted activities.
- In the event emergency treatment/aid is required I wish the following procedure to take place:

SIGNATURE	DATE
PRINT NAME BELOW IF SIGNATURE ABOVE IS BY A PARENT OR GUARDIAN FOR A VOLUNTEER UNDER 18	
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Dear CHAMP Rider,

We may request you to be part of a CHAMP promotional press release. We appreciate your willingness to participate in aiding us to maintain the program through such promotions. For legal reasons we require that you understand and agree to the releases below by filling them out and signing both.

Sincerely,
Champlain Adaptive Mounted Program

RIDER: _____ DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____

CITY/ STATE/ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

PHOTO RELEASE

I do do not consent to and authorize the use and reproduction by Champlain Adaptive Mounted Program of any and all photographs and any other audio-visual materials taken of me/my son/my daughter/my ward for promotional use, educational activities, and exhibitions or for any other use for the benefit of the program.

SIGNATURE _____ DATE _____

PRINT NAME BELOW IF SIGNATURE IS BY A PARENT OR GUARDIAN _____

RELATIONSHIP _____

INFORMATION FOR PRINT RELEASE

I do do not consent to and authorize the use and reproduction of any and all interviews done by members of the press for the purposes of promoting the Champlain Adaptive Mounted Program (CHAMP). I will not hold any CHAMP instructor or volunteer or the authors or publishers of any article liable for statements they may make about me and my participation in this program based on the information provided in interviews. I further understand that I am participating solely for the promotion and fundraising to benefit the CHAMP programs and that there will be no compensation made to me by CHAMP or the publishing organizations.

SIGNATURE _____ DATE _____

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