2022 S.T.A.R.S. Rider Registration Form

(Special Training and Riding Skills)

Please Print

Name:	Date of Birth:	Age:	Sex:	Home: Cell: Please circle the preferred contact #

Address:	City:	State:	Zip:	E-mail address:

Rider's Support Person(s): (Parent, Staff)	Relationship to the Rider:

Support Person Address:	City:	State:	Zip:	E-mail address:

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 where S.T.A.R.S. is conducted, I authorize S.T.A.R.S. staff 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.

Signature: _____ Date: _____

Liability Release

I, _____ would like to participate in the S.T.A.R.S. program. I acknowledge the risks and potential for risks of a horseback riding program. However, I feel that the possible benefits to myself are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assignees, executors, or administrators, waive and release forever all claims for damages against S.T.A.R.S., its board of directors, instructors, therapists, volunteers and/or employees for all injuries and/or losses I may sustain while participating in S.T.A.R.S.

Signature of parent/guardian or adult rider: _____ Date: _____

WARNING: Under South Dakota Law, and Equine professional is not liable for an injury to or the death of a participant in Equine activities resulting from the inherent risks of Equine activities, Pursuant to 42-11-2.

Photo Release

I hereby consent to and authorize the use and reproduction by S.T.A.R.S. of all photographs and any other audiovisual materials taken of me for promotional printed materials, educational activities, exhibitions, or any other use for the benefit of the program.

Signature of parent/guardian or adult rider: _____ Date: _____

Policies and Payments:

Please initial next to each statement below to indicate we have communicated clearly.

_____ Riders must attend each session with a parent, guardian, or support person who understands well the nature of any disability or chronic illness and who is authorized to make decisions regarding the rider's health and safety.

_____ It is expected that riders arrive on time, appropriately dressed wearing long pants and closed heel and toe shoes.

_____ In order to facilitate S.T.A.R.S., we count on several volunteers that commit their time and energy to make this program possible. Please notify S.T.A.R.S. 24 hours in advance if a rider will be absent. In case of last-minute emergency, please notify S.T.A.R.S. as soon as possible.

_____ The fee for each Session is $40.00. There is a discount for multiple-family members participating (2 family members for $60.00). All payments are non-refundable.

_____ Balance is due with this registration from. Scholarship assistance is available. If you need scholarship assistance, please call (605) 690-0259 or email S.T.A.R.S. Program Director, Kristine Skorseth, (brookingsstars.director@gmail.com) to request a scholarship.

Session Choice:

(Mark as many as you wish to participate in.) Please mark your preference for riding time. (1 for first choice and 2 for second choice)

_____ Initial _____	Session #1, Ride #1	$40	**May 31, June 2, 7, 9, 14, 16, 21, 23**	**5:30-6:30 PM**
_____ Initial _____	Session #1, Ride #2	$40	**May 31, June 2, 7, 9, 14, 16, 21, 23**	**6:30-7:30 PM**
			Make up rides June 28 and 30 due to weather cancellations	
_____ Initial _____	Session #2, Ride #1	$40	**July 12, 14, 19, 21, 26, 28, August 2, 4**	**6:00–7:00 PM**
_____ Initial _____	Session #2, Ride #2	$40	**July 12, 14, 19, 21, 26, 28, August 2, 4**	**7:00-8:00 PM**
			Make up rides August 9 and 10 due to weather cancellations	
_____ Initial _____	Session #3, Ride #1	$40	**August 16, 18, 23, 25 ,30, September 1, 6, 8**	**5:30-6:30 PM**
_____ Initial _____	Session #3, Ride #2	$40	**August 16, 18, 23, 25 ,30, September 1, 6, 8**	**6:30-7:30 PM**
			Make up rides September 13 and 15 due to weather cancellations	

T-Shirt Size: _____ Child's Sm _____ Child's Med _____ Child's Lg _____ Sm ____ Med _____ Lg

_____ XLg _____ 2XLg _____ 3XLg

What is the goal for the rider? (Example: core strength, social outing, laps, etc.)

Consent for Release of Information

I hereby authorize: _____ to release information from the records of _____
(Person or Facility) (Client's Name)

The information is to be released to S.T.A.R.S. (Special Training and Riding Skills) for the purpose of developing a Therapeutic Riding Program for the above-named client. The information to be released is marked below.

____ Medical History
____ Classroom Individual Education Plan
____ Speech Therapy evaluation, assessment, and program plan
____ Physical Therapy evaluation, assessment, and program plan
____ Occupational Therapy evaluation, assessment, and program plan

Signature: _____ Date: _____
(Please send the indicated material to Program Director)

Information for Physician

The following conditions, if present, may represent precautions or contradictions to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic		Medical/Surgical		Neurologic	Secondary Concerns
Spinal Fusion	Heterotrophic Ossification	Poor Endurance	Allergies	Hydrocephalus/shunt	Behavior problems
Scoliosis	Osteogenesis Imperfecta	Recent Surgery	Cancer	Hydromyelia	Age under two years
Kyphosis	Internal Spinal Stabilization Devices	Varicose Veins	Diabetes	Tethered cord	Age two-four years
Lordosis	Spinal instabilities/Abnormalities	Hemophilia	Hypertension	Spina Bifida	Acute exacerbation of chronic disorder
Osteoporosis	Pathologic Fractures	Peripheral Vascular Disease		Chiari II Malformation	Indwelling catheter
Coxa Vara	Atlantoaxial Instabilities	Serious Heart Condition		Seizure Disorder	
Cranial Deficits	Hip Subluxation and Dislocation	Stroke (Cerebrovascular Accident)		Paralysis due to Spinal Cord Injury	
Spinal Deficits					

Rider's Medical History and Physician's Statement

(To be completed annually)

Please Note: S.T.A.R.S. will accept a current health statement from a Special Olympics application. You do not need to get another health statement for S.T.A.R.S. Please attach your Special Olympics health statement to this form.

Rider's Weight: _____

Name:	Date of Birth:	Address:
Name of Parent/Guardian:	Diagnosis:	

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.

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

Mobility	Independent Ambulation ___ Yes ___ No	Crutches ___ Yes ___ No	Braces ___ Yes ___ No	Wheelchair ___ Yes ___ No

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding program will weigh the medical information above against the existing precautions and contradictions. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (PT, OT, Speech Therapist, Psychologist, etc.) in the implementing of an effective program.

Physician Name: (Please Print)	Phone #:
Physician Signature:	Date:
Physician's Address: (Include City, State, Zip)	