

HEALTH HISTORY - Please indicate current or past problems in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Emotional			
Circulation			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

Authorization for Emergency Medical Treatment

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Physician's Name: _____ Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Current Medications: _____

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 Victory Riding Academy 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.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: ___/___/___ **Consent Signature:** _____

Client, Parent, or Legal Guardian

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:

Date: ___/___/___ **Consent Signature:** _____

Client, Parent, or Legal Guardian

Victory Riding Academy

RELEASE AND INDEMNIFICATION AGREEMENT

I, the undersigned, hereby request permission to participate in the programs offered by Victory Riding Academy, Inc. ("VRA"); which programs may necessarily require my handling and control of animals and access to restricted areas of VRA and other facilities where VRA programs are offered, from time to time.

Acknowledgement and Assumption of Risk. In consideration of and as a condition to my ability to participate in VRA programs and/or enter VRA premises, I voluntarily and willingly enter in to this Waiver and Release of Liability. I acknowledge and agree there are inherent risks associated with equine activities and hereby expressly assume all risks associated with participating in such activities. I represent and warrant that I have the requisite skill and experience to participate in such activities. The inherent risks associated with equine activities include, but are not limited to, the propensity of equines and other saddle animals to behave in ways such as, running, bucking, biting, kicking, shying, stumbling, rearing, falling, or stepping on, that may result in an injury, harm or death to persons on or around them; the unpredictability of equines' reaction to such things as sounds, sudden movement and unfamiliar objects, persons or other animals; certain hazards such as surface and subsurface conditions; collisions with other animals, the limited availability of emergency medical care; and the potential of a volunteer or participant to act in a negligent manner that may contribute to injury to the volunteer, participant or others, such as failing to maintain control over the animal or not acting within such volunteer or participant's ability.

Release. I further acknowledge that horses and other saddle animals, by their very nature, are unpredictable and subject to animal whim. With such understanding, I, my respective personal representatives, assigns, heirs, and next-of-kin, hereby waive, release and forever discharge VRA, its directors, officers, agents, representatives, employees and volunteers ("Releasees") from any and all claims, demands, losses or damages relating to any injury, to me and/or my property, including, but not limited to, death or injury caused or alleged to be caused, in whole or in part, by my actions or inactions, or the actions or inactions of the Releasees, unless caused by Releasees' gross negligence. I assume all risks in connection with my presence on VRA's premises or activities on behalf of VRA, and expressly waive any claims for any injury or loss arising therefrom. I agree to abide by and follow VRA's rules and regulations, which shall be posted and/or available in VRA's office from time to time.

Indemnification. Furthermore, I agree, for myself and my heirs, to indemnify and defend and hold harmless Releasees from any loss, liability, damage, claims, costs (including attorneys' fees), action, causes of action, or proceedings of any kind for personal injury or loss of personal property arising out of or in any way related to my participation or presence on VRA premises, or my willful or grossly negligent actions or inactions, except to the extent caused by the gross negligence of Releasees.

Medical Care/Covenant not to Sue. In case of sickness, accident or injury, VRA has my express permission to secure, at my expense, such medical treatment as it deems necessary in its sole discretion. I understand that Releasees do not carry health insurance on me and that Releasees assume no financial responsibility for any medical, health, or disability payments. I agree and covenant that I will not now or at any time in the future, directly or indirectly, commence or prosecute any action, suit or other proceeding against any of the Releasees for damages of any type arising from or related to my participation or presence on VRA premises.

Miscellaneous. This document shall be broadly construed and governed in accordance with the laws of the State of Nebraska. If any portion of this Waiver and Release of Liability shall be held invalid or unenforceable for any reason, the remaining provisions shall continue to be valid and enforceable. If a court of law or equity finds that any provision of this Waiver and Release of Liability is invalid or unenforceable, but that by limiting such provision it would become valid and enforceable, then such provisions shall be deemed to be written, construed, and enforceable as so limited.

I grant VRA, the right to take photographs and/or videos of me or audio recordings of my voice during the participation activities and grant VRA all right, title and interest in any such photographs, videos and recordings. VRA may reproduce, publish, circulate, sell and otherwise use on behalf of VRA, any and all photographic and video likenesses of me and audio recordings of my voice. I waive any right to inspect any final artwork or copies containing my likeness or voice prior to any publication by VRA and acknowledge that the rights granted herein to VRA are perpetual and not limited in time.

I HAVE READ THIS WAIVER AND RELEASE OF LIABILITY AND UNDERSTAND THAT BY SIGNING IT I GIVE UP SUBSTANTIAL RIGHTS THAT I WOULD OTHERWISE HAVE TO RECOVER DAMAGES FOR LOSS OCCASIONED BY THE ACTIONS OR INACTIONS (INCLUDING NEGLIGENCE) OF RELEASEES, AND SIGN IT VOLUNTARILY AND WITHOUT INDUCEMENT AS OF THE DATE SET FORTH BELOW.

I UNDERSTAND THAT UNDER NEBRASKA LAW, AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM INHERENT RISKS OF EQUINE ACTIVITIES, PURSUANT TO NEB. REV. STAT. §§ 25-21,249 TO 25-21,253.

I understand that it is a requirement of VRA to wear a riding helmet and utilize other safety gear appropriate to my level of experience while on a horse.

Executed the _____ day of _____, 20_____.

Print Name: _____ Signature: _____

(Parent/Guardian)

Victory Riding Academy

Improving the quality of life for students with equine-facilitated activities.

Serving Douglas County and surrounding areas since 2012

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

(To be filled out by Rider's Physician only)

Date: _____

Participant: _____ DOB: _____ Height: _____ Weight _____

Address: _____ City: _____ Zip: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs: _____

Mobility: Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N

Braces/Assistive Devices: _____

Tetanus Shot: Yes No

For Those with Down syndrome: Atlantoaxial Instability (AAI) X-rays, date: _____ Result: + or -

Please indicate current or past difficulties in the following systems/areas, including surgeries:

Areas	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			

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

Name/Title (MD, DO, NP, Other): _____ Phone: _____

Signature: _____ Date: _____ License/UPIN Number: _____