MARION THERAPEUTIC RIDING ASSOCIATION, INC.
6850 SE 41st Ct, Ocala, FL 34470 (352) 732-7300 execdirector@mtraocala.org

Rider/Driver Application and Health History

(PLEASE PRINT) **Current date:_____**

Participant's Name:_____

Date of Birth: _____ Male/Female: ____ Age: ____ Weight: ____ Height: _____

□ Parent or □ Guardian _____

Address: _____City: _____ State: ___ Zip: _____

Telelphone: Home: _____ Mobile: _____

Cell/Mom: _____ Cell/Dad _____ Cell/Guardian: _____

E-mail address: _____

Note: Complete the following only when parent/guardian is NOT the contact person:

Contact Name: _____Relationship _____

Telehpone: Home: _____ Work:_____ Cell:_____

Family Gross Income Level: (select one) **$ 9,000 to 15,000 ____** **$15,001 to 24,000 ____** **$24,001 to 45,600 ____** **$45,601 and up ____** **Receive government financial assistance: Yes____ No ____**	**Indicate one:** **1) White ____ 2) Black _____** **3) Asian ____ 4) Hispanic ____** **5) Other (list heritage) _____** **Family size: _____** **Veteran: Yes ____ No ____**

Participant's Disability (required):

_____

_____

Date of Onset: _____

HEALTH HISTORY:

Parent/Guardian please list current or past physical, emotional, or mental conditions that require consideration when the applicant is participating in any equine related activity—including but not limited to riding, driving, handling horses etc.). Be specific. For example: 'limited or no vision in right eye; brace on left ankle, uncontrollable outburst of anger; fear of heights/animals/horses; allergic reaction to dust/animal dander; onset of seizure indicator; rods in back; shunts in us,e etc.'

NOTE: Regardless of your physician's permission/release, the final decision for participation in equine related activities rests with MTRA's Executive Director.

MEDICAL INFORMATION:

Physician's Name: _____
Physician's Address: _____ Phone #: _____
Health Care Insurance Co.: _____ Policy #: _____

MEDICATIONS:
What medications are you currently taking, including over the counter medications? (Be sure to let us know when medications are added or changed).

_____
_____
_____

AMULATORY STATUS:
Please describe: _____
_____
_____
_____

EMERGENCY CONTACT:

Person who is authorized to give temporary assistance or care in absence of parent or guardian:

NAME: _____

PHONE # _____ **RELATIONSHIP** _____

Medical conditions requiring special precautions or treatment. Please check one:
(A) None _____ **(B)** Yes, please describe below_____:

_____
_____

EMERGENCY MEDICAL RELEASE:

In case of a **Medical Emergency**, the undersigned authorizes **Marion Therapeutic Riding Association, Inc.** to provide such medical assistance as they determine to be necessary.

In the event that the preferred physician (listed above) cannot be reached, the undersigned authorizes any medical, surgical care, and/or hospital staff to provide care, including anesthetic, for the participant which they determine necessary or advisable, pending receipt of a specific consent from the undersigned.

No rider or driver can be accepted for riding or driving instruction until this form has been completed by the Parent/Parents or Guardian/Guardians. If the rider or driver is of legal age (18), he or she may complete the form, if he or she is legally competent to do so.

Yes, I would like _____ to have riding/driving instruction, and I have discussed this with the doctor.

SIGNATURE OF CLIENT *IF LEGAL AGE* (18)_____

SIGNATURE OF PARENT OR GUARDIAN *IF UNDERAGE* _____

(*Print name of parent or guardian*) _____

MARION THERAPEUTIC RIDING ASSOCIATION, INC.

Please read and sign both sections.

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!!WARNING!!

UNDER FLORIDA LAW, AN EQUINE ACIVITY SPONSOR OR 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. FL STATUTE #s773.01

LIABILITY RELEASE AGREEMENT

_____**(Client's Name)** would like to participate in the **Marion Therapeutic Riding Association, Inc.** riding and/or driving 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 **Marion Therapeutic Riding Association, Inc.,** its Board of Directors, personnel/volunteers, Hillcrest School and Marion County School Board for any and all injuries and/or losses I / my son / my daughter / my ward may sustain while participating in riding or driving at **Marion Therapeutic Riding Association, Inc.**

Date: _____ **Signature:**_____

(Client, Parent or Guardian)

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PHOTO RELEASE

I ☐ **DO**

☐ **DO NOT**

consent to and authorize the use and reproduction by **Marion Therapeutic Riding Association, Inc.** 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 **Marion Therapeutic Riding Association, Inc.**

Date: _____ **Signature:**_____

(Client, Parent or Guardian)