MARION THERAPEUTIC RIDING ASSOCIATION, INC.
6850 SE 41st Court, Ocala, FL 34480
Phone #: (352)732-7300
information@mtraocala.org

[redacted]

Participant and Health History Forms

(PLEASE PRINT)

Participant's Name:_____ **Current date:**_____
Date of Birth: _____ **Male/Female:** ____ **Age:** ____ **Weight:** ____ **Height:** _____
☐ **Parent or** ☐**Legal Guardian Name:** _____
Address: _____**City:** _____ **State:** ___ **Zip:** _____
Home #: _____ **Work # (list owner):** _____
Cell#/Mom: _____ **Cell#/Dad** _____ **Cell #/Guardian:**_____
E-mail address: _____

NOTE: Complete the following *only* when the Parent(s) and/or Guardian(s) are NOT the contact person:
Contact Person's Name:_____ **Contact's Relationship to Participant:**_____
Home #: _____ **Work #:**_____ **Cell #:**_____

For grant purposes, please complete the following:		**Indicate one:**
Family Gross Income Level:	**$ 9,000 to 15,000 ____**	**1) White ____ 2) Black _____**
(select one)	**$15,001 to 24,000 ____**	**3) Asian ____ 4) Hispanic ____**
	$24,001 to 45,600 ____	**5) Other (list heritage) _____**
	$45,601 and up ____	**Family size: _____**
Receive government financial assistance: Yes____ No ____		**Veteran: Yes ____ No ____**
		Female Head of Household: Yes ___ No___

REQUIRED INFORMATION

Participant's Disability:_____
Date of Onset (when did symptoms begin): _____

HEALTH HISTORY (REQUIRED):

Parent/Legal Guardian please list ***current*** or ***past*** physical, emotional, and/or mental conditions that require consideration when the participant is engaging in ***any*** equine related activity. This includes, but is not limited to riding and other equine assisted activities. **BE SPECIFIC**. Examples include: Limited or no vision in right eye; Brace on left ankle; Uncontrollable outburst of anger; Fear of heights, animals, and/or horses; Allergic reaction to dust and/or animal dander; Onset of seizure indicator (such as heat); Rods in back; Shunts in use. If no current or past conditions apply, please write NA.

NOTE: Regardless of your physician's permission/release, the final decision for participation in therapeutic riding and/or equine related activities rests with MTRA's Program Coordinator.

Revised: May 2013

MEDICAL INFORMATION:

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

MEDICATIONS:
What medications is the Participant currently taking? This does includes over the counter medications.
NOTE: Be sure to let us know when medications are added or changed.

_____
_____
_____

AMBULATORY STATUS:
Can the Participant walk without any assistance? If no, does he or she use crutches, braces, walker or a wheelchair? Please describe:

EMERGENCY CONTACT:

Person who is authorized to give temporary assistance or care in absence of parent or legal 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**, I _____ (Client, Parent, or Legal Guardian) authorize **Marion Therapeutic Riding Association, Inc.** to provide such medical assistance as they determine to be necessary.

In the event that the **physician listed above cannot be reached**, I _____ (Client, Parent, or Legal Guardian) authorize any medical care, surgical care, and/or hospital staff to provide care, which includes anesthetic, for the participant which they determine necessary or advisable.

No rider can be accepted for riding instruction until this form has been completed by the Parent/Parents or Legal Guardian/Legal Guardians. **IF** the participant 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 instruction, and I have discussed this with his or her doctor.

SIGNATURE OF Parent OR Legal Guardian*:* _____

PRINT NAME OF Parent OR Guardian: _____

PLEASE READ AND SIGN *BOTH* SECTIONS

!!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 #773.01

LIABILITY RELEASE AGREEMENT

_____**(Client's Name)** would like to participate in the **Marion Therapeutic Riding Association, Inc.** therapeutic horseback riding and/or equine assisted activities program. I acknowledge the risks and potential for risks of therapeutic riding and equine assisted activities. However, I feel that the possible benefits to me/my son/ my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound for me/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**, **Marion County Board of Commissioners, state of Florida and the Cross Florida Greenways and Trails,** for any and all injuries and/or losses me/my son/my daughter/my ward may sustain while participating in equine assisted activities at **Marion Therapeutic Riding Association, Inc.**

Signature: _____ **Date:** _____
(Client, Parent or Legal Guardian)

PHOTO RELEASE

I ☐ **DO**
☐ **DO NOT**

authorize and consent to 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.**

Signature: _____ **Date:** _____
(Client, Parent or Legal Guardian)