



Serenity Therapeutics LLC

753 North Main St, Suite B5, Cottonwood AZ 86326

928-899-0723 info@SerenityTherapeuticsLLC.com

STUDENT/RIDER REGISTRATION FORM

Limited spaces are available and are reserved on a first come, first served basis. ~ Session fee is due on or before the first day of the session. No rider will be permitted to ride until full payment is received. You may visit our website or contact the site office for an application. **STUDENTS RIDING HORSES CANNOT EXCEED 180 LBS. THIS IS DUE TO THE SAFETY OF OUR HORSES AND STAFF. THERE IS NO WEIGHT RESTRICTION FOR THOSE WHO ARE ONLY DOING GROUNDWORK AND NOT RIDING. HELMETS MUST BE WORN AT ALL TIMES WHILE ON HORSES AND/OR IN THE ARENA.**

Student Information

Student: _____ Date of Birth: _____ Age _____

Street Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Height: _____ Weight: _____ Gender: M / F

School or Institution Attending: _____

Student's Disability (Primary/Secondary): _____

Seizures: YES / NO Controlled: _____ Date of last seizure: _____

Allergies: _____

Parent/Legal Guardian: _____ Email _____

Address (if different than above): _____

Positive Reinforcers: _____

How did you hear about Serenity Therapeutics LLC? _____

Please state a few personal goals you would like to achieve through our programs: _____

Is there anything you'd like to share with us about the student? _____

Emergency Contact Information

Name (1st): _____ Phone: _____ Relations ip: _____

Name (2nd): _____ Phone: _____ Relations ip: _____

Billing Information

Primary Contact: _____ Phone: _____ Relations ip: _____

Street: _____ City/State: _____ Zip: _____

Phone: _____ Alternate Phone: _____ Email: _____

Photo Release

I hereby consent to and authorize the use and reproduction by Serenity Therapeutics any and all photographs and any other audio materials taken of me and my child for promotional printed materials, internet, website and educational activities or for any other use.

Signature: _____ Date' _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, volunteering or while on the property of the agency, I authorize Serenity Therapeutics 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 or emergency treatment.

Name: _____ Date of Birth: _____ Age: _____
Street Address: _____ City: _____ Zip: _____
Phone: _____ Alternate Phone: _____ Email: _____

Consent Plan

This authorization includes X-rays, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Date: _____ Consent Signature: _____

Print Name: _____

Emergency Contact Information

Name: _____ Phone: _____

Name: _____ Phone: _____

Physician: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Carrier: _____ Policy Number : _____

Allergies, Medical Conditions & Medications (Please list any pertinent medical issues, special situations, seizure activity, etc.)

Non- Consent Plan

I **DO NOT** give my permission for emergency medical aid/treatment if required due to illness or injury during the process of receiving services, volunteering or while on the property of the agency. In the event emergency aid/treatment I is required, I wish the following procedures to take place:

Date: _____ Non-Consent Signature: _____

Print Name: _____

Privacy Statement: Serenity Therapeutics, takes your privacy very seriously. All information provided to us is held in the strictest confidence and security. We will never trade, sell or rent your personal information to anyone under any circumstance! Your personal information, such as your address and email, will only be used by Serenity Therapeutics for event, volunteer, program, etc. announcements.



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DEAR PHYSICIAN:

Your patient is interested in Therapeutic Horseback Riding/Equine Therapy. Each student must submit a completed physician assessment form and release to enroll in our program. Your completion of this form will assist our instructors in designing an individual lesson plan for your patient that is first and foremost safe in addition to being effective. To ensure the safety of your patient (our client/student), please fill these forms out carefully and completely. **Please do not leave any blank spaces.**

Equine Therapy/Therapeutic Horseback Riding is widely accepted as a useful method of improving the physical, mental and emotional well-being of those individuals with disabilities. The horse's soothing rhythm, strength, warmth and three-dimensional movement pattern provides healthy exercise while improving circulation and muscle tone. The discipline associated with working with horses and the social interactions between peers benefit the mind, body and spirit, raising self-esteem and increasing self-sufficiency through accomplishment. The unconditional love and acceptance of the horse is proven to reduce anxiety, encourage interaction and offer a safe haven while riders can feel a sense of empowerment. Please feel free to call or visit if you would like more information.

Sincerely,

Serenity Therapeutics

STUDENT/RIDER'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Name: _____ Date of Birth: _____ Height: _____ Weight: _____

Street: _____ City/State _____ Zip: _____

Diagnosis: _____ Date of onset: _____

Past/Prospective Surgeries: _____

Seizure Type: _____ Controlled: Yes / No Date of Last Seizure: _____

Shunt Present: Yes / No Date of Last Revision: _____

Special Precautions/ Needs: _____

Current Medications: _____

Allergies: _____

Mobility: Independent Ambulation? Yes / No Assisted Ambulation? Yes / No Wheelchair? Yes / No

Draces Assisted Devices: _____

Please indicate current deficits in the following systems/areas. Please include surgeries (if Yes, please comment)

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Skills			
Cognitive			
Emotional/Psychological			
Pain Tolerance			
Other			

For those with Down Syndrome: Atlanto Dens Interval X-Rays: Date: _____ Result: _____

Neurologic Symptoms of Atlanto Axial Instability: _____

PHYSICIAN'S RELEASE

Name: _____ Date of Birth: _____

The following conditions, if present, may represent precautions and contraindications to Equine Therapy/Therapeutic Horseback Riding. Please circle below any of the following conditions present:

<p>ORTHOPEDIC Spinal Fusion Spinal Instabilities/Abnormalities Atlantoaxial Instabilities Scoliosis (please indicate degree. ____ _ Kyphosis Lordosis Hip Subluxation & Dislocation Osteoporosis Pathologic Fractures Coxas Arthrosis Heterotopic Ossification Osteogenesis Imperfecta Cranial Deficits Spinal Orthoses Internal Spinal Stabilization Devices</p>	<p>MEDICAL/SURGICAL Allergies Cancer Poor Endurance Recent Surgery Diabetes Peripheral Vascular Disease Varicose Veins Hemophilia Hypertension Serious Heart Condition Stroke (CVA)</p>
<p>SECONDARY CONCERNS Behavior Problems Age Less Than Two Years Age Two-Four Years Acute Exacerbation of Chronic Disorder Indwelling Catheter</p>	<p>NEUROLOGIC Hydrocephalus/shunt Spina Bifida Tethered Cord Chiari Malformation Hydromyelia Paralysis Due to Spinal Cord Injury Seizure Disorder</p>

Physician Statement

To my knowledge there is no reason why the above named patient can not participate in supervised equestrian activities. However, I understand that Serenity Therapeutics - Equine Assisted Activities and Therapy Center will weigh the medical information above against any existing precautions and/or contraindications before accepting this individual for Therapeutic Horseback Riding lessons. I concur with a review of this individual's abilities limitations by a licensed/credentialed health professional (e.g. Physical, Occupational, Speech Therapist, Psychotherapist, etc.) in the implementation of a safe and effective equestrian program.

Physician Signature: _____ Date: _____

Print Name: _____ Phone: _____

Street: _____ City/State: _____ Zip: _____

PLEASE NOTE: THIS FORM IS VALID FOR A PERIOD OF ONE YEAR FROM THE DATE SIGNED AND MUST HOLD THE ORIGINAL PHYSICIAN SIGNATURE. STUDENT CAN NOT PARTICIPATE IN ANY EQUINE ASSISTED ACTIVITY OR THERAPY UNTIL SERENITY THERAPEUTICS ALL SIGNED AND COMPLETED DOCUMENTS.

LIABILITY RELEASE AND HOLD HARMLESS AGREEMENT

PLEASE READ CAREFULLY BEFORE SIGNING SERIOUS INJURY MAY RESULT FROM YOUR PARTICIPATION IN THIS ACTIVITY

A. REGISTRATION OF STUDENT/RIDER AND AGREEMENT PURPOSE AND CONSIDERATION - In consideration of my enrollment in the Serenity Therapeutic Therapies program and the signing of this agreement, I, the following listed individual and the parents or legal guardians thereof, 'I' a minor, do hereby voluntarily request and agree to participate in activities and events at THIS STABLE. PARTICIPANT shall ride a horse provided by THIS STABLE for lesson purposes today and on all future dates. This agreement shall be legally binding upon the PARTICIPANT and the parents or legal guardians thereof if a minor, my heirs, estate, assigns, including minor children and personal representatives. It shall be interpreted according to the laws of the state and county of THIS STABLE'S physical location. Any disputes by the rider shall be litigated in the county in which THIS STABLE is located.

B. Information about student/rider:

Name: _____ DOB: _____ Age: _____

Address: _____

C. DEFINITIONS - The term "THIS STABLE" shall herein refer to Serenity Therapeutics, Instructors, volunteers and employees. The term "HORSEBACK RIDING" or "RIDING" shall herein refer to riding or otherwise handling of horses whether from the ground or mounted. The term "HORSE" shall herein refer to all equine species. The terms "PARTICIPANT" and/or "STUDENT/RIDER" shall herein refer to a person who rides a horse mounted or otherwise handles or comes near a horse from the ground. The terms "I", "Me", "My", "Participant", and "Rider" shall herein refer to the above registered rider and ~ ie parents or legal guardians thereof if a minor.

D. ACTIVITY RISK CLASSIFICATION. INHERENT RISKS AND NATURE OF THE HORSE WARNING

Horseback riding is classified as a RUGGED ADVENTURE RECREATIONAL SPORT ACTIVITY. There are numerous obvious and non-obvious inherent risks always present in such activity despite all safety precautions According to NEISS (National Electronic Injury Surveillance Systems of United States Consumer Products) horse activities rank approximately 64th among the activities of people relative to injuries that result in a stay at U.S. hospitals. Related injuries can be severe requiring more hospital days and resulting in more lasting residual effects than injuries in other activities. NO HORSE IS A COMPLETELY SAFE HORSE. Horses are 5 to 15 times larger, 20 to 0 times more powerful and 3 to 4 times faster than a human is. If a rider falls from a horse to the ground it will generally be at a distance of from 3 1/2 to 5 1/2 feet and the impact may result in injury or death to the rider. Horseback riding is the only sport where one much smaller, weaker predator animal, the human, tries to control and become one u . of movement with another much larger, stronger prey animal, the horse, with each having a limited understanding 01 the other. If a horse is frightened or provoked it may divert from its training and act according to its natural survival instincts which may include but are not limited to: stopping short; changing directions or speed at will; shifting its weight from side to side, bucking, rearing, biting, kicking or running from perceived danger.

E. STUDENT/RIDER ACCEPTANCE OF RESPONSIBILITY - PARTICIPANT AGREES that he/she has in some way satisfied himself that the condition of the premises and the facilities will provide an adequate and reasonable level of safety for PARTICIPANT. THIS STABLE is not responsible for any property damage. injury or loss of life incurred by or as a result of any horse(s) on this premises to PARTICIPANT. PARTICIPANT IS AWARE IF T : RISKS AND DANGERS OF THIS ACTIVITY AND AGREES TO ACCEPT RESPONSIBILITY FOR ANY AND A_L INCIDENTS OCCURRING DURING THIS ACTIVITY.

F. CONDITIONS OF NATURE - THIS STABLE is not responsible for total or partial acts, occurrences, or elements of nature that can scare a horse, cause it to fall or react in some other unsafe way. SOME EXAMPLES: Thunder, lightning, rain and wind. Wild and domestic animals, insects, reptiles which may walk, run, fl near, bite or sting a horse or person; and irregular footing on indoor and out of door groomed or wild land which is subject to constant change in condition according to weather, temperature and natural or man-made changes in la scape.

G. ACCIDENT ALIMEDICAL INSURANCE - Should emergency medical treatment be required, I and/or my own medical insurance company shall pay all such incurred expenses. My accidental/medical insurance company is: _____ My policy # _____

H. RIDING HELMET WARNING - RIDER is hereby warned and informed by THIS STABLE that all horse handlers and riders should wear a properly fitted and secured protective EQUESTRIAN riding helmet that meets ASTM standards. Such helmets are available at THIS STABLE; however, THIS STABLE recommends the PARTICIPANT purchase their own helmet to receive the benefit of a custom fit. Wearing such headgear while mounting, riding, dismounting, and being around horses may prevent death or reduce the severity 0 head injuries resulting from a fall or other incident involving a horse. THIS STABLE abides by the NARHA Helmet l'landards and requires children under the age of 14 to wear an ASTM approved EQUESTRIAN helmet when mounted ,at all times.

I. LIABILITY RELEASE - In consideration of THIS STABLE allowing my participation in this activity, under the terms set forth herein, I, the PARTICIPANT and the parent or guardian thereof if a minor, do agree to old harmless and release THIS STABLE, its Board of Directors, instructors, agents, volunteers, employees, offices, members, affiliated organizations and insurers from legal liability due to THIS STABLE'S ordinary negligence. I do 'further agree that except in the event of THIS STABLE'S gross and willful negligence, I shall bring no claims, derr -mds, actions, causes of action and/or litigation against THIS STABLE and its associates as stated above in this c:1 ause, for any economic and non-economic losses due to bodily injury, death, property damage, sustained by me ar llor my minor child or legal ward in relation to the premises and operations of THIS STABLE. This Includes while ridi ,handling, or otherwise being near horses owned by or in the care, custody and control of THIS STABLE or on the prc.perty of THIS STABLE for any reasons.

J. BREACH OF CONTRACT- Should either party breach this contract, the breaching party shall pay for the other's court costs and attorney fees related to such breach.

ALL RIDERS, PARENTS, LEGAL GUARDIANS OR AUTHORIZED AGENTS MUST SIGN BELOW AFTER READING THIS ENTIRE DOCUMENT.

STATEMENT OF AWARENESS AND CONFIDENTIALITY

I/WE the undersigned, have read and do understand the foregoing agreement, warnings, assumption of risk and release agreement. I/WE further attest that all stated facts are true and accurate.

Client/Volunteer/Parent/Guardian (Please Print) _____

Client/Volunteer/Parent/Guardian Signature: _____

*Client, Volunteer, Parent or Guardian (if volunteer is under 18, Parent/Guardian must sign)

State of Arizona Title 12. Courts and Civil Proceedings. Chapter 5. Limitations of Actions. Article 3. Personal Actions. § '-553. Limited liability of equine owners and owners of equine facilities; exception; definitions. Citation: AZ ST § 12-553 Citation: A. R. S. § 12-553 Summary: This Arizona statute provides that an equine agent or owner is not liable for injury if the participant to k control of the equine prior to injury, if a parent or guardian signed a release on behalf of a minor, if the owner or agent has l) operly installed suitable tack or the participant has personally tacked the equine, or the owner or agent assigns a suitable equine based on a reasonable interpretation of the person's representation of his or her skills, health and experience with and knowledge of equines. Liability is not limited, however, when an equine owner or agent is grossly negligent or commits willful, wanton or intentional acts or omissions.



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PARTICIPANT CONSENT FOR RELEASE OF INFORMATION

I hereby authorize: _____

(Person of Facility)

To release information from the records of: _____ DOB: _____

(participant name)

This information is to be released to Serenity Therapeutics for the purpose of developing an equine assisted activity program for the above named participant. The information to be released is checked below.

- _____ Physical, Occupational and Speech therapy evaluations, and program plan.
- _____ Classroom Individual Education Plan
- _____ Cognitive Behavioral Management Plan
- _____ Other

(Please print name or Parent/Guardian Name)

Signature of Client, Parent or Guardian (if client is under 18, Parent/Guardian must sign)

Date

Please send the information indicated above to:

Serenity Therapeutics
1088 S UVX Road
Cottonwood, AZ 86326

POLICIES AND PROGRAM RULES

1. PAPERWORK

- All paperwork and fees **MUST** be received by the office prior to the beginning of the riding session. There will be **NO** exceptions.
- The Student/Rider Registration Form **MUST** be received prior to you/your child receiving confirmation of a scheduled class. Full payment **MUST** be received before the first class of the session.

2. LESSONS

- To accommodate everyone, lessons must start on time. Anyone arriving 15 minutes late will participate in stable work only. Anyone arriving more than 25 minutes late will forfeit the lesson entirely and will not be reimbursed.
- If a rider cannot attend class for any reason once the session has started, there will be no refunds.
- Parents/Guardians or counselors must remain on the premises during the rider's scheduled class. For safety reasons, Serenity Therapeutics has established a rider weight limit of 180 lbs. Riders over 180 cannot be accommodated and may, however, participate in our Equine Facilitated Learning program.
- At **NO** time may an individual enter an arena where lessons are in progress, unless otherwise authorized by the certified instructor and liability forms are complete and signed.

3. CLOTHING

- Long pants should be worn during lessons regardless of weather.
- Preferably, riders should wear a boot or shoes with a heel. All footwear must have a closed heel and toe (**NO** clogs, sandals, flip-flops, etc.). This policy applies for riders riding in a bareback pad, English or Western saddles.

4. RIDER'S CONDITION

- The Equine Program Director and Instructors must have current information about all elements of your child's condition in order to be able to provide the most effective instruction and ensure the safety of all participants. Please keep us informed of any changes in you/your child's condition or medication.

5. BARN RULES

- Children and guests of riders must be supervised and must adhere to the rules and policies at all times.
- No eating or chewing gum while on the property. Water bottles are allowed.
- No child under the age of 14 will be allowed in the barn/horse area without supervision.
- All children under the age of 14 and all students/riders in the program must wear a helmet at all times when in the barn area.
- There is absolutely no hand feeding of the horses; please advise a staff member if you brought horse treats and they will supervise and accommodate you/your child.
- No one is permitted on the property unless a staff member is on the premises.
- No running or screaming.
- No one may enter a pasture containing horses.
- No outside pets (i.e. dogs, cats, etc.) are allowed on the property.
- Infectious diseases (if you have equines yourself): please be considerate of our therapy horses - some equine diseases are contagious (i.e. strangles) and we would not want that brought into the barn area.

6. GENERAL

- No abusive, threatening or violent behavior will be tolerated from **ANYONE** for **ANY REASON**. Absolutely **NO SMOKING** on the property.
- Report all accidents, injuries or hazardous conditions to a staff member as soon as possible.
- Parking is permitted in designated areas of the property. Please drive slowly (5 mph), as classes may still be in progress.

POSSIBLE REASONS FOR CLIENT DISCHARGE

1. Uncontrolled and inappropriate behavior that constitutes a safety risk to staff, volunteers and/or therapy horses.
2. Client weight exceeds that which can safely be managed by staff, volunteers and/or therapy horses.
3. Any change in client's medical, physical, cognitive or emotional condition that makes Therapeutic Riding inappropriate.

DISMISSAL OF VOLUNTEERS AND GUESTS FROM CENTER ACTIVITIES

Serenity Therapeutics relies greatly on volunteers as important members of the team who provide services to and assist our clients. We also recognize the extreme importance of the safety and well-being of our clients, volunteers, staff, guests and animals.

All volunteers and guests (Guests = siblings, parents, other relatives, friends, HAS providers, counselors, etc.) are expected to follow Serenity Therapeutics rules and policies and may not engage in disruptive, unsafe or inappropriate behavior. In the event a volunteer or guest does not comply, the following actions may be taken:

Level 1- Verbal Warning:

Breaking of Serenity Therapeutics rules and/or policies and procedures may be followed by a verbal warning from the Equine Program Director, Executive Director or any member and be documented in the incident report book.

Level 2- Written Warning:

Breaking of Serenity Therapeutics rules and/or policies and procedures for a second time will be followed by a Personnel/Staff meeting for discussion regarding the infraction. The purpose of the meeting is to determine the exact reason the infraction occurred for a second time and discuss with the volunteer/guest how to avoid the circumstance ever occurring again. This meeting will be documented and placed in the incident report book.

Level 3- Dismissal from organization:

Immediate dismissal from the property and organization will occur for:

- Endangering the safety of others
- Inappropriate use of the facilities, mailing lists or monies
- Disruptive or abusive behavior to the animals or individuals at Serenity Therapeutics
- Repeated disregard of the organization's rules, policies and procedures
- Possession of a weapon, illegal drugs or paraphernalia
- Being under the influence of alcohol or drugs

Please cut the bottom, signed portion and return with your registration forms. Keep the above for your reference and records.

DISMISSAL OF VOLUNTEERS AND GUESTS FROM CENTER ACTIVITY

I have read and understand the policies and program rules by which Serenity Therapeutics. By signing below, I indicate my willingness to abide by these rules and policies. I further understand that failure to comply with these policies and rules result in discharge from the program.

Client/Parent/Guardian (Please Print): _____

Client/Parent/Guardian Signature: _____

Insurance Information

Clients Name: _____

Date of Birth: _____

1.Primary Insurance carrier: _____

Phone Number: _____

Subscriber Number: _____

Group Number: _____

Primary insured: _____

Date of Birth of primary insured: _____

Effective Date: _____

2. Secondary Insurance _____

Phone Number: _____

Subscriber Number: _____

Group Number: _____

Primary insured: _____

Date of Birth of primary insured: _____