Beekman Therapeutic Riding Center
Community and Therapeutic Riding

PARTICIPANT APPLICATION
(Please print all information in a legible format)

Riding Program: Beekman Student Community Rider Therapy Non-Therapy

GENERAL INFORMATION:

Participant Name:_____DOB_____Age_____

Address_____

City_____State_____Zip_____County_____

Gender: M F Height_____ Weight_____* 175 pound limit

Parent/Legal Guardian_____

Address (if different from above)_____

Email Address_____

Phone: primary_____ other_____

School/Program_____

Person/Party Responsible for payment_____

Relationship to Rider_____

Billing Address/Phone # (if different from above)_____

_____

GOALS

What would you like to accomplish in our program?_____
_____

Additional information that would be helpful in class selection and lesson planning:_____
_____

Please list any accommodations/concerns the instructors should be aware of:_____
_____

Has the participant had any prior experience with horseback riding? YES NO

Other information we should know_____
_____

Warning: Under the Michigan equine activity liability act, an equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of the equine activity.

Beekman Therapeutic Riding Center
Community and Therapeutic Riding

LIABILITY RELEASE FORM

I agree to the following agreement with the Beekman Therapeutic Riding Center, a Michigan nonprofit corporation (hereafter referred to as "Center") as a condition for allowing me, and the persons identified below, to enter the Center's premises and surrounding land, be near horses, participate in equine-assisted activities, work near horses, participate in hay rides, handle horses, use equipment, work with staff and volunteers, and/or receive instruction or guidance in riding, grooming, or handling horses (these activities will hereafter be referred to in this document as "The Activities").

Participants Name_____
Parent/Guardian if Participant is under 18_____
Spouse or other Parent_____
Home Address_____
Phone_____

IT IS HEREBY AGREED AS FOLLOWS:

I/we are aware and acknowledge the inherent dangers, hazards and risks, associated with equine activities. I/we understand that the inherent risks of the equine activities mean those dangerous conditions which are integral part of the equine activities, including but not limited to:

1. The propensity of any equine to behave in ways that may result in injury, harm or even death to persons on or around them and/or damage to property in their vicinity.
2. The unpredictability of an equine's reaction to such things as sounds, sudden movement and unfamiliar objects, persons or other animals.
3. The equine's response to certain hazards such as surface and sub-surface objects.
4. Collisions with other equines, animals, people and objects.

The potential of any participant to act in a negligent manner that may contribute to injury to the participant or others, such as falling to maintain control over the equine or to act within his/her ability.
I/we assume these risks and accept the consequences involved in the participation of the participant registered on this form. I/we accept the responsibility for complying fully with all safety regulations and practices. I/we will consult with the instructor of the Beekman Therapeutic Riding Center for advice in circumstance where safe practices are in doubt.

Warning: Under the Michigan equine activity liability act, an equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of the equine activity.

I/we have read and fully understand the content of this release of liability and agree to comply with the intent to hold harmless or to indemnify BTRC, or the Lansing Educational Advancement Foundation, the Lansing School District, its' staff, volunteers or any other individuals and/or organizations involved, from any liability or injury that may result from the participation in activities in this program.

I/we understand that BTRC always recommends that I/we seek the advice of a physician, and many of The Activities pose special physical risks to the participant and even to the volunteer. I/we acknowledge that it is my/our responsibility to make BTRC aware of any conditions that may affect my ability to handle, ride, and/or be near an equine.

I/we have received information on the signs, symptoms & consequences of concussions in accordance with Public Acts 342 and 343 of 2012. By signing below, I acknowledge that I have read, fully understand, and agree to be bound by the provision of this release.

Signature of parent/guardian/participant of legal age Date

Beekman Therapeutic Riding Center
Community and Therapeutic Riding

Authorization for Medical Treatment

_____ I give my consent, that in case of a medical emergency, the undersigned authorizes the Beekman Therapeutic Riding Center to provide such medical assistance as they determine necessary. The undersigned authorizes any licensed physician and/or medical facility to provide medical surgical care and/or hospitalization for the participant, including anesthetic, which they may determine to be necessary or advisable, pending receipt of a specific consent from the undersigned.

_____I do not give consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being present on the property of the agency (BTRC). In the event of an emergency treatment/aid is required, I wish the following procedures to take place:_____
_____
_____

Emergency contact person Relationship to participant

Phone Number Signature

PHOTO AND VIDEO RELEASE

I/we authorize the appropriate use of any photographs, audio or video footage that may capture the image of the participant. These photos may be taken during an event or a class that the participant has enrolled in. Photos or videos may be used on the BTRC website, public media, newspapers or magazines.

Signature of parent/guardian/participant of legal age Date

No participation can be accepted for riding instruction until this form has been completed and signed. If the participant is of legal age (18), he or she may complete this form, if he/she is legally competent to do so. Riding instruction will be under strict supervision, and although every effort will be made to avoid any accident.
Warning: Under the Michigan equine activity liability act, an equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of the equine activity.

UNDERSTANDING CONCUSSION

Headache	Pressure in the Head	Nausea/Vomiting	Dizziness
Balance Problems	Double Vision	Blurry Vision	Sensitive to Light
Sensitivity to Noise	Sluggishness	Haziness	Fogginess
Poor Concentration	Memory Problems	Confusion	"Feeling Down"
Not "Feeling Right"	Feeling Irritable	Slow Reaction Time	Sleep Problems

WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a fall, bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. A concussion can be caused by a shaking, spinning or sudden stopping and starting of the head. .Even a 'ding," "getting your bell rung, " or what seems to be a mild bump or blow to the head can be serious. A concussion can happen even if you haven't been knocked out.

You cannot see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the participant reports any symptoms of concussion, or if you notice symptoms yourself, seek medical attention right away. A participant who may have had a concussion should not return to play on the day of the injury and until a health care professional says they are okay to return to the program.

IF YOU SUSPECT A CONCUSION:

1. SEEK MEDICAL ATTENTION RIGHT AWAY – A health care professional will be able to decide how serious the concussion is and when it is safe for the participant to return to regular activities, including sports. Don't hide it, report it. Ignoring symptoms and trying to "tough it out" often makes it worse.
2. KEEP YOUR PARTICIPANT OUT OF ACTIVITIES – Concussions take time to heal. Don't let the participant return to activities the day of the injury and until a health professional says that it is okay. A person who returns to activities to soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the person for a lifetime. They can also be fatal. It is better to miss one game/activity than the whole season/session.
3. TELL THE SCHOOL/PROGRAM ABOUT ANY PREVIOUS CONCUSSIONS – Schools/Programs need to know if a person has had a previous concussion, The persons school/program may not know about a concussion received in another sport/activity unless you notify them.

SIGNS OBSERVED BY PARENTS:

Appears dazed or stunned	Cannot recall events prior to or after a hit
Answers Questions Slowly	Is confused about assignment or position
Is unsure of game, score, opponent	Moves clumsily
Loses consciousness (even briefly)	Shows mood or behavior, or personality changes
Forgets Instructions	Slow reaction time

CONCUSSION DANGER SIGNS:

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. A person should receive immediate medical attention if after a bump, or jolt to the head or body he/she exhibits any of the following danger signs:

One pupil larger than the other	Repeated vomiting or nausea	Unusual behavior
Drowsy or cannot be awaken	Slurred speech	Loses consciousness
A headache that gets worse	Convulsions or seizures	Decreased coordination
Weakness or numbness	Cannot recognize people/places	

HOW TO RESPOND TO A REPORT OF A CONCUSSION:

If a person reports one or more symptoms of a concussion after a bump, blow, or jolt to the head or body, he/she should be kept out of activities the day of the injury. The person should only return to the activity with permission from a health care professional experienced in evaluating for concussion. During recovery, rest is key. Exercising or activities that involve a lot of concentration (studying, computer usage, video games) may cause the symptoms to reappear or get worse. Those who return to activities may need to spend fewer hours, take rest breaks, be given extra help and time. After a concussion, returning to sports, activities and school is a gradual process that should be monitored by a health care professional. Remember, that concussions affect each person differently. While most people with a concussion recover quickly and fully, some will have symptoms that last for days or even weeks. A more serious concussion can last for months or longer.

To learn more go to: www.cdc.gov/concussion or www.cdc.gov/headsup

*National Federation of State High School Associations Concussion in Sports training course which is available at https://nfhslearn.com/courses/61037. The Center for Disease Control's Heads-Up Concussion in Youth Sports training course, which is available at http://www.cdc.gov/HeadsUp/youthsports/training/index.html

Beekman Therapeutic Riding Center
Community and Therapeutic Riding

MEDICAL HISTORY AND PHYSCIAN'S STATEMENT

This form is not valid without the dated signature of a Parent/Legal Guardian and a Medical Examiner.
This form will be kept on file and must be renewed every 3 years for continued participation.
Information updates will be done annually.

First Name & Initial	Last Name	Email address	Date of Birth (mm/dd/yy)
Address		Phone Number	Gender M F
City, State, Zip Code		Health Insurance Company	Policy Number
Parent/Guardian First Name	Parent/Guardian Last Name	Name of Insurance Policy Holder	
Parent/Guardian Address if different than above		Policy Holder's Employer	
City, State, Zip Code		Name of Emergency Contact other than Parent/Guardian	
Parent/Guardian Phone #	Participant Diagnosis/Disability	Phone Number of Emergency Contact	

Please check Yes or No to the following:

YES	NO	
		Heart disease/Defect/High Blood Pressure
		Fainting/heatstroke/exhaustion
		Seizures: Frequency_____
		Diabetes: Type I or II
		Concussion/Serious Head Injury
		Visual Impairment
		Hearing Impairment
		Special Diet
		Asthma or Exercise Induced Wheezing
		Tendency to Bleed
		Emotional/Psychiatric/Behavioral Problems
		Immunizations are up to date
		Impairment requiring specialized equipment
		Shunts/Rods
		Urination/Bowel Problems
		Tactile Sensitivities
		Joint Replacement
		Communication Issues
		Major Surgery or Serious Illness
		Allergies
		Balance or Muscle Tone Issues
		Down Syndrome, please list the date of the lst AtlantoDens Interval X-ray:_____ Result:
		Takes Medications

For any "YES" responses, please explain here.

MEDICAL CERTIFICATION SECTION
To be completed by examiner

Skin	Head	Eyes	Ears
Nose	Mouth/Throat	Neck	Lungs
Heart	Abdomen	Extremities	Other
Height	Weight	Blood Pressure	

List concerns/conditions that Beekman Therapeutic Riding Center should be aware of for this Participant:

I have examined the individual named in this application and reviewed the health information provided, and I certify that there is no medical evidence available to me which would preclude this person from participation in an equine activity program under appropriate supervision.

Signature of Examiner	Title
Printed Name	Date
Address	Phone

Note to Examiner: if the participant has Downs Syndrome it is required that a full radiological exam be conducted which certifies the absence of atlantoaxial instability before they may participate in equine activities. Please note the date of the x-ray and those finding's here.

List medications here. If more than 4, attach a separate sheet.

Medication Name	Dosage	Time Taken	Date Prescribed