

## BAR NONE THERAPEUTIC RIDING

### STUDENT APPLICATION

This entire form must be completed and signed in order to be accepted, except for the photo release form (optional).  
 Please return to Bar None Cowboy Church, attn: Therapeutic Riding, 9162 State Highway 43E, Tatum, TX 75691,  
 If you have any questions please email us at barnonecc@gmail.com, or call 903-836-7224

Name	DOB	AGE
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Diagnosis	Height	Weight
Under the age of 18: <b>Y</b> or <b>N</b>	Parent/Guardian	
Work place	Mobile phone	

I am /My child is: Ambulatory            verbal Non-ambulatory    non-verbal	I use/My child uses: Wheelchair           braces Crutches                other
I/My child: Can    cannot    sit independently	I would like to apply for a scholarship: <b>Y</b> or <b>N</b>

In case of emergency, I give permission to Bar None Therapeutic Riding to secure medical treatment including x-ray, surgery, hospitalization and medication.

Signature of student or guardian if under the age of 18 \_\_\_\_\_ Date \_\_\_\_\_

**If not enough space is provided below please attach to the back of this application.**

Medications: (include prescription, over-the-counter: name, dose and frequency. Attach list to this form if necessary)
Describe abilities/difficulties in the following areas (include assistance required or equipment needed): PHYSICAL FUNCTION:(mobility)
SOCIAL FUNCTION:
PAST/PROSPECTIVE SURGERIES:
GOALS

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**STUDENT PHOTO RELEASE**

(Circle one)

**I DO** or **I DO NOT** consent to and authorize the use and reproduction of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If under 18 must be signed by parent or guardian

**STUDENT LIABILITY RELEASE**

I, undersigned, adult student, or parent or guardian of \_\_\_\_\_, would like to participate at Bar None Therapeutic Riding, (hereinafter referred to as BNTR). I acknowledge the risk and potential for risks of horseback riding. I understand the various populations served at BNTR and understand that teens participating in BNTR’s Juvenile Intervention Program including adjudicated and /or troubled teens may be acting as volunteers and may be on the BNTR premises. I understand that I /my son/daughter/ward, will be working with and around horses, as well as riding horses at BNTR, however, I feel that the possible benefits to myself/son/daughter/ward are greater than the risk assumed. I the undersigned student and /or parent forever release, acquit, discharge and hold harmless all claims for damages against BNTR, its board of directors, trustees, agents, instructors, therapists, employees, representatives, successors, assigns, volunteers, owners of the property on which BNTR operates, for any and all manner of claims, demands and damages of every kind or nature whatsoever, which student may now or in the future have against BNTR, its board of directors, trustees, agents, instructors, therapists, employees, representatives, volunteers, owners of property on which BNTR operates, successors, Elders, Lay Pastors or assigns on account of any personal injuries and/or personal damages known or unknown.

I understand that under the *Texas Equine Liability Act (Chapter 87, Civil Practice and Remedies Code)*, an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risk of equine activities.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## TO BE COMPLETED BY PHYSICIAN

Name	Date of Birth	Age
Address		
Diagnosis	Date of Onset	

Shunt Present: Y or N	Date of last revision:
Tetanus Shot : Y or N	Date of last shot:
Seizure Type:	Controlled: Date of last seizure:

**\*\*For persons with Down Syndrome:**

Cervical X-ray for Atlantoaxial Instability: Positive or Negative Date: \_\_\_\_\_

Before being accepted as a student, it is essential that the questions are thoroughly and completely answered so that each student's abilities and limitations are given due consideration by BNTR's trained Instructors, the student's Physician and Therapist.

Special Precautions: \_\_\_\_\_

Specific body movements or positions <b>NOT</b> to be attempted
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Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no.

Areas	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning disability			
Mental Impairment			
Psychological Impairment			
Paui			
Other			

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications.

Physicians Name Printed: \_\_\_\_\_

**Physicians Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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# AVAILABILITY FORM

NAME: \_\_\_\_\_

Telephone (mobile preferred): \_\_\_\_\_

Address: \_\_\_\_\_

RIDER or VOLUNTEER (circle one)

Please place an X in the box on the days and times you would be available to participate.

	Monday	Tuesday	Wednesday	Thursday	Friday
8-9am					
9-10					
10-11					
11-12					
12-1pm					
1-2					
2-3					
3-4					
4-5					

How often would you like to participate?

Weekly      Bi-weekly      Monthly      Bi-monthly

Please use this space to provide any additional information about your schedule.