# Freedom Ride Inc

1905 Lee Road, Orlando, FL 32810
Phone: 407-293-0411 / Please return originally completed forms to the office

| PARTICIPANT REGISTRATION INFORMATION – PLEASE WRITE CLEARLY IN INK | | |
|---|---|---|
| Complete Name: | | |
| Nickname: | Date of Birth: | |
| Mailing Address: | | |
| City: | County: | Zip: |
| City of Orlando Resident: ☐ Y ☐ N | Email Address: | |
| Home: | Cell: | Other: |

| PARENT/CAREGIVER / EMPLOYER / SCHOOL INFORMATION | |
|---|---|
| **Name**- Parent(s)/Guardian: | |
| **Employer**- Father: | Work#: |
| **Employer**- Mother: | Work#: |
| **Name**- Caregiver/Guardian: | Phone: |
| School/Institution Participant presently attending: | |

| PHOTO RELEASE (CHECK ONE) | |
|---|---|
| ☐ **I DO** hereby consent to and authorize the use and reproduction by Freedom Ride and the City of Orlando 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 the program.<br>-OR-<br>☐ **I DO NOT** give consent to use the above use of photo or video graphic materials. | |
| Adult Signature: | Date: |

| AUTHORIZATION OF EMERGENCY MEDICAL TREATMENT | |
|---|---|
| In the event emergency medical aid/treatment is required, due to illness or injury, during the process of receiving services or while being on the property of the agency, I authorize Freedom Ride to:<br>1. Secure and retain medical treatment and transportation, if needed<br>2. Release client records upon request to the authorized individual or agency involved in the emergency medical treatment. | |
| Emergency Contact: | Relationship: |
| Physician Name: | |
| Preferred Medical Facility: | |
| Health Insurance Company: | Policy: |
| ☐ **CONSENT PLAN** – I GIVE consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. 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 and/or cannot give authorization at the time of occurrence.<br>-OR-<br>☐ **NON-CONSENT PLAN** – I DO NOT give consent for emergency medical treatment/aid in the case of illness or injury while participating in activities with Freedom Ride, Inc. In the event emergency medical treatment/aid is required, I wish the following procedures to take place: | |
| Adult Signature: | Date: |

☐ Participant ☐ Parent ☐ Legal Guardian

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## PARTICIPANT LIABILITY RELEASE FORM

| Participant Full Name: | Date of Birth: |
|---|---|

**UNCONDITIONAL GENERAL RELEASE**

**WARNING-UNDER FLORIDA LAW, AN EQUINE ACTIVITY 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.**

I, _____, a participant, client, volunteer, or student or the legal guardian of a participant, client, volunteer, or student ("Participant") in a program, event, or activity taking place under the sponsorship of or at the facilities of **FREEDOM RIDE, INC.**, a Florida not for profit corporation ("Freedom Ride"), hereby give consent and approval to the participation of Participant in any and all programs, events, or activities taking place under the sponsorship of or at the facilities of Freedom Ride ("Activities").

I fully understand that my decision to be a Participant or to allow such person named above to be a Participant, poses risks of personal injury, property damage, death and/or other loss that may arise while participating in the Activities. I assume all risk and hazards incidental to the conduct of the Activities as well as transportation to and from all Activities.

In consideration of Participant's being allowed to participate in the Activities, on behalf of Participant, Participant's heirs, personal or legal representatives, successors and assigns, I hereby irrevocably and unconditionally release, and covenant not to sue Freedom Ride, the City of Orlando, and each of Freedom Ride and the City of Orlando's owners, directors, officers, employees, agents, independent contractors, representatives, attorneys, successors, and assigns, and all persons acting by, through, under, or in concert with, any of them (collectively "the Releasees"), from any and all claims or causes of action whatsoever, in law or in equity, whether known or unknown at this time, based on any action, cause or thing occurring on, prior to, or following the date hereof, and, in particular, without limiting the generality of the foregoing, all claims arising out of or relating to the Activities, even if such liability or damage results from the sole negligence of the Releasees.

I hereby authorize the Releasees to act in their discretion on behalf of Participant in providing, requesting, or authorizing the provision of emergency medical services ("Emergency Services"). I acknowledge full responsibility for any charges associated with the rendering of any and all Emergency Services, and I indemnify the Releasees from any and all claims, expenses, or other charges related to their decision to provide or to not provide Emergency Services.

I understand and agree that this document shall be construed according to the laws of the State of Florida, and that this Unconditional General Release shall be as broad and inclusive as is permitted by the laws of the State of Florida. If any portion of this document is held to be invalid or of no force or effect, I agree that the balance shall continue in full force and effect.

This Unconditional General Release shall be immediately effective upon its execution.

**I HAVE READ AND UNDERSTAND THIS DOCUMENT**. **DATED** this ___ day of _____ 20___.

| Print Name: | Date: |
|---|---|
| Adult Signature: | Date: |

☐ Participant ☐ Parent ☐ Legal Guardian

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| MEDICAL HISTORY AND PHYSICIAN'S RELEASE – MUST BE COMPLETED BY PHYSICIAN | | |
|---|---|---|
| Name: | | |
| DOB: | Height: | Weight: |
| Address: | | |
| Name of ☐ Parent or ☐ Guardian: | | |
| Primary Diagnosis: | | Date of Onset: |
| Secondary Diagnosis: | | Date of Onset: |
| Tertiary Diagnosis: | | Date of Onset: |
| Shunt Present: ☐ Yes ☐ No<br>Date of Last Revision: | | Tetanus Shot: ☐ Yes ☐ No<br>Date if Yes: |
| Seizure Type: | | Controlled: ☐ Yes ☐ No<br>Date of Last Seizure: |

| PLEASE LIST ALL CURRENT MEDICATIONS | |
|---|---|
| 1. | Taken for: |
| 2. | Taken for: |
| 3. | Taken for: |
| Any contagious diseases: | |

| Please indicate if a patient has a problem and/or surgeries in any of the following areas. If yes, please comment, using the back of the form if necessary | | | |
|---|---|---|---|
| Areas | Yes | No | Comments |
| Auditory | | | |
| Visual | | | |
| Speech | | | |
| Cardiac | | | |
| Circulatory | | | |
| Pulmonary | | | |
| Neurological | | | |
| Muscular | | | |
| Orthopedic | | | |
| Allergies | | | |
| Learning Disabilities | | | |
| Mental Impairment | | | |
| Psychological Impairment | | | |
| Incontinence | | | |
| Coordination | | | |
| Balance | | | |

| | |
|---|---|
| Independent Ambulation: ☐ Yes ☐ No | Crutches: ☐ Yes ☐ No |
| Wheelchair: ☐ Yes ☐ No | Braces: ☐ Yes ☐ No |
| Past/Prospective Surgeries: | |
| Special Precautions/Needs: | |

**Physician's signature required on other side (page 2)**

| PHYSICIAN INFORMATION | | | |
|---|---|---|---|
| The following conditions, if present, may represent precautions and contraindications to therapeutic horse riding. Please be sure to clearly identify and check the boxes if any of the following conditions are present and explain to what degree. | | | |
| **Orthopedic** | | **Medical / Surgical** | |
| Atlantoaxial Instabilities | | Allergies | |
| Coxas Arthrosis | | Cancer | |
| Cranial Deficits | | Diabetes | |
| Heterotopic Ossification | | Hemophilia | |
| Hip Subluxation and Dislocation | | Hypertension | |
| Internal Spinal Stabilization Devices | | Peripheral Vascular Disease | |
| Kyphosis | | Poor Endurance | |
| Lordosis | | Recent Surgery | |
| Osteogenesis Imperfecta | | Serious Heart Condition | |
| Osteoporosis | | Stroke (Cerebrovascular Accident) | |
| Pathologic Fractures | | Varicose Veins | |
| Scoliosis | | | |
| Spinal Fusion | | | |
| Spinal Instabilities/ Abnormalities | | | |
| Spinal Orthoses | | **Neurologic** | |
| | | Chiari II Malformation | |
| **Secondary Concerns** | | Hydrocephalus/shunt | |
| Acute exacerbation of chronic disorder | | Hydromyelia | |
| Age two - four years | | Paralysis due to Spinal Cord Injury | |
| Behavior problems | | Seizure disorders | |
| Indwelling catheter | | Spina Bifida | |
| Integumentary/Skin | | Tethered Cord | |

| PARTICIPANTS WITH DOWN SYNDROME – PLEASE NOTE & COMPLETE |
|---|
| Due to the nature of the activity of horseback riding, no individual diagnosed with Down Syndrome can be accepted for riding instruction without proof of an annual medical clearance from a licensed physician that includes a neurological exam that specifically denies any symptoms consistent with Atlantoaxial Instability. |
| Annual neurological exam for Atlantoaxial Instability: ☐ Positive ☐ Negative Date of exam: |

| PHYSICIAN VERIFICATION – PLEASE PRINT YOUR NAME, SIGN & DATE – THANK YOU | | |
|---|---|---|
| **To my knowledge, there is NO REASON why this person cannot participate in supervised equestrian activities. However, I understand that the final decision regarding acceptance rests with the Freedom Ride, Inc. staff, upon due consideration of the participant's special needs, precautions and contraindications, and the safety of the participant, staff, volunteers and horses.** | | |
| Physician Name/Title (Please Print): | | |
| Signature: | Date: | Phone: |
| Address: | | |
| Additional Comments: | | |
| | | |
| | | |

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| PARTICIPANT QUESTIONNAIRE | |
|---|---|
| The following questionnaire is designed to give Freedom Ride information pertaining to each individual participant's behavior and ability. This will help us prepare lesson plans and assist you in attaining individual goals. Please complete the questionnaire in as much detail as possible using the back of the page or attaching an additional sheet if necessary. | |
| Name: | Age: |
| 1. Briefly describe his/her disability: | |
| | |
| | |
| 2. What are the physical symptoms of the disability: | |
| | |
| | |
| 3. What goals do you hope he/she will achieve by participating in this program: | |
| | |
| | |
| 4. What other treatments or therapies has he/she undergone? Please specify when and for how long: | |
| | |
| | |
| 5. How would you describe his/her concentration, attention span and general awareness: | |
| | |
| | |
| 6. Would you characterize him/her as happy, aggressive, easygoing, enthusiastic, passive, excitable, depressed, introverted or extroverted: | |
| | |
| | |
| 7. Is he/she able to understand language? How does he/she communicate? | |
| | |
| | |
| 8. Is there a history of incontinence: | |
| 9. What positive reinforcements does he/she respond to: | |
| | |
| | |
| 10. Please use the rest of this sheet to indicate any other areas of behavior and personality that will help us best communicate, understand and work with him/her at Freedom Ride: | |
| | |
| | |
| Signature: | Date: |

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| PARTICIPANT STATISTICAL INFORMATION FORM - FOR STATISTICAL USE ONLY | | |
|---|---|---|
| Completion of this form will assist Freedom Ride in tracking information needed to apply for grant funding for the program. The information received from this form will remain confidential. The information will not affect the decision for a participant to ride with Freedom Ride. | | |
| Participant Name: | | |
| Gender: ☐ Female ☐ Male | Date of Birth: | |
| Mailing Address: | | |
| City: | County: | Zip: |
| Disability: | | |

| RACE | |
|---|---|
| ☐ American Indian / Alaskan | ☐ Hispanic |
| ☐ Asian / Pacific Islander | ☐ White (non-Hispanic) |
| ☐ Black | ☐ Other |

| ANNUAL HOUSEHOLD INCOME (PLEASE CHECK) | |
|---|---|
| ☐ $0-10,000 | ☐ $31-50,000 |
| ☐ $11-20,000 | ☐ $51- 75,000 |
| ☐ $21-30,000 | ☐ $75,000 + |
| Number in Family: | Number of Employed Family Members: |
| Adult Signature: | Date: |
| ☐ Participant ☐ Parent ☐ Legal Guardian | |

| REFERRAL INFORMATION |
|---|
| How did you hear about the program?<br>☐ Website ☐ Media ☐ Doctor ☐ Therapist ☐ Participant ☐ Other: |