Participants Release and Hold Harmless Agreement
THIS RELEASE LIMITS OUR LIABILITY
READ IT!

Riding: ☐ **Volunteer:** ☐ **EAP:** ☐ **Vaulting:** ☐ **Other:** ☐

By signing this form, I acknowledge that therapeutic, pleasure horse riding and vaulting is a dangerous activity, which may result in injury to my horse, or me or result in damage to my equipment. With this knowledge, in consideration for the services of Special Spirit Therapeutic Equine Center (Special Spirit), and as inducement for the services of Special Spirit to provide therapeutic pleasure horse riding and/or physical therapy on horseback to me, I hereby waive, release, discharge and hold harmless Special Spirit, its officers, directors, employees and volunteer assistants, the facilities Moonshadow Ranch and Sullivan Canyon Property, their heirs, executors, administrators, successors or assigns, from any and all liability for damages sustained by me, any animal owned or controlled by me, or for any item or personally under my dominion and control. Without limiting the generality of the above, I hereby waive and release Special Spirit, its officers and directors and all volunteer assistants for liability based on the active or passive negligence of said persons and entities.

I hereby agree to indemnify and hold harmless Special Spirit, its officers, directors and all volunteer assistants associated therewith for any claims which may be made against them, including attorney's fees and costs of suit in any action based upon or arising from my acts or omissions, or the actions of any animal within my control.

This release extends to all claims, whether presently known or unknown. I hereby expressly waive any benefits I may have pursuant to Section 1542 of the California Civil Code relating to the release of unknown claims, which provides: "A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release which if known by him must have materially affected his settlement with the debtor."

I acknowledge that I have read the foregoing and understand the contents thereof.

Dated _____/20__ _____ _____

Signature of rider or visitor to Moonshadow Ranch — Riders or visitors Printed name

Address : _____

City, State_____ Phone: _____

E-mail: _____*) Cell #: _____

In Case of Emergency, notify: _____

Phone #: _____ _____

*) Your e-mail will be added to our Special Spirit Newsletter – Please mark the box if you do not want to be on Special Spirit Newslett☐

Photo Release - ☐ I DO ☐ I DO NOT

Consent to and authorize the use and reproduction by Special Spirit of any and all photographs and any other audio/visual materials taken of me for the promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

MINORS MUST HAVE THE FOLLOWING SIGNED BY THEIR PARENTS OR LEGAL GUARDIANS

I, the undersigned parent or guardian _____ of _____ for and in consideration of our child's participation at Special Spirit Therapeutic Equine Center state that I have read the waiver, release and hold harmless written above and I expressly agree that the terms and conditions of said waiver, release and hold harmless shall apply to and be binding upon me and my minor child or his or her horse may sustain or cause as a result of said participation. I further warrant I have health and accident insurance for said minor.

Dated _____ _____

Parent of Legal Guardian

● 9889 Helen Avenue ● Shadow Hills ● CA ● 91040 ● P: (323)661-3090 ● E: info@specialspirit.org ●
A NON PROFIT 501(c)3 CORP ID# 26-2504871 www.specialspirit.org

Rider Registration

Program Information Date_____

Participant Name: _____ Phone: _____

DOB_____Age_____Height_____Weight_____ Gender M F

Primary Diagnosis_____

Secondary Diagnosis_____

Mobility status (walks unassisted, assistant devices, etc) _____

Issues to Address_____

Communication (verbal, non-verbal signs) _____

Behaviors (impulsive, fearful, frustration tolerance) _____

Medications Taken_____

Seizures (if applicable please describe) _____

Limitations_____

Allergies_____

Skin sensitivity_____

Participant's occupation/ school grade level_____

Affiliate Program if applicable_____

Personal Goals (fill in the areas that apply) _____

Physical_____

Cognitive_____

Social/Behavioral_____

Life skills_____

Other_____

Availability for Special Spirit Program (Mark available time/day in order of preference)

Tue am_____ Tue pm_____ Wed am_____ Wed pm_____ Thu am_____ Thu pm_____

Fri am_____ Fri pm_____ Sat am_____ Sat pm_____

Start Date_____ (Decided at the evaluation)

Rider's Medical History and Physician's Statement

Name: _____

Address_____City:_____Zip:_____

Phone Number:_____ E-Mail:_____

Date of Birth: _____ Name of Parent/Guardian:_____

Diagnosis: _____ Date of Onset: _____

Tetanus Shot: Yes: ___ No: ____ Date: _____ Height: _____ Weight: _____

Seizure Type: _____ Controlled: _____ Date of Last Seizure: _____

Medications: _____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

***** Only For Persons with Down Syndrome***

Cervical X-ray for Atlantoaxial Instability: Positive: _____ Negative: _____ X-Ray Date: _____

Area	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation:Yes __ No __ Crutches:Yes__ No __ Braces:Yes __ No _

Wheelchair: Yes __ No __ Please indicate any special precautions: _____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Special Spirit Inc Therapeutic Riding Center will weigh the medical information above against the existing precautions and contradictions. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician Name (please print) _____

Physician Signature _____Date _____

Address _____ City _____ State ___ Zip _____

Phone _____

Special Goals:

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Authorization for Emergency Medical Treatment

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Medical Facility: _____

Health Care Insurance: _____ Policy #: _____

Allergies to Medications: _____

Current Medications: _____

In the event of an emergency contact:
Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical treatment is required due to illness or injury during the process of receiving services or while being on the premises of Special Spirit Inc. facility, I hereby authorize the Special Spirit Inc. staff to secure and retain medical treatment and transportation if needed and to release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and treatment procedure deemed necessary as life saving by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: _____ Consent Signature: _____
Client, Parent or Legal Guardian

Non-Consent Plan

I do not give consent for the emergency medical plan listed above and instead request the following procedures to take place: _____
_____

Date: _____ Consent Signature: _____
Client, Parent or Legal Guardian

Special Spirit - Rider Goals

Please help us help you get the most out of your classes by filling out the following goal setting sheet. Please hand back to your instructor at the next class. Thank you.

Rider name: _____
Parent name: _____
Email address: _____
Class day/time: _____

All goals are reflective of the next term. The categories are meant as a guideline and may not apply to all students.

Riding goals: _____
_____
_____
_____

Physical goals: _____
_____
_____
_____

Cognitive goals: _____
_____
_____
_____

Social goals: _____
_____
_____
_____

Goals Dated: _____

Client Contact and Payment Information

Participant Name: _____

Address_____

City/State/Zip_____

Home Phone_____Cell_____

Email Address_____

Names of parents/guardian:

Father_____Cell_____Email_____

Mother_____Cell_____Email_____

Best Emergency Contact:

Name_____Phone_____Cell_____

Parent occupation and employer:

Father_____ Work Phone_____

Mother_____ Work Phone_____

How were you referred to Special Spirit?_____

Program Tuition Payment Details

Please tell us how you will be paying:

○ Check - Please make payable to Special Spirit

○ Credit Card - By signing this form, you authorize Special Spirit to charge your credit card on a recurring basis for lesson payments of either single lesson $85.00 or package of 4 lessons $300.00.

I_____authorize Special Spirit to charge $_____

to my credit card. Date_____Name on Card_____

Cardholder signature_____Billing zip code_____

Card Number_____Exp._____CSV _____

○ Other:_____

I understand and agree that all paperwork must be up to date, and that **all tuition is to be paid prior to the start of each session**.

Signature of Rider or Legal Guardian_____Date_____

Special Spirit Riding Lesson Fee-2024

LESSON FEE

Single lesson **- $85.00**

Monthly (4 lessons) **- $300.00**
** Monthly package must be purchased at the beginning of each month and all lesson must be taken within the same month.*

** Clients purchasing lesson packages will have priority for scheduling.*

CANCELLATION POLICY: Cancellation notice must be made 24 hours prior to the scheduled lesson in order to receive credit for the lesson. We do not offer cash refunds but will be glad to reschedule your lesson within the month of purchase.

Notice given less than 24 hours prior to lesson and "No Shows" will be charged for the missed lesson.

EVALUATION

One-time fee of $75.00

An accredited teacher will spend approximately 30-45 minutes "one on one" with your child to assess his or her level of need, their goals and ability will determine the lesson plan.

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Possible Reasons for Client Discharge

Please be advised of the following reasons that may lead to discharge from the riding program.

1. The client has reached all of their goals and is ready to graduate.
2. The client's potential to maintain head and neck control while riding presents a safety concern.
3. Inability to follow directions is interfering with progress toward goals.
4. Uncontrolled and/or inappropriate behavior that constitutes a safety risk to client, staff and/or horse.
5. Client exceeds weight that can safely be managed by staff, volunteers, and/or horses.
6. Any change in the client's medical, physical, cognitive, or emotional condition that makes therapeutic riding inappropriate.
7. Three scheduled appointments are missed without prior cancellation.
8. Non-payment of fees as originally agreed.

I understand and agree with the possible reasons for client discharge.

Signature of Client or Legal Guardian:_____

Date:_____