Panther Creek Inspiration Ranch

E-mail: michelle@inspirationranch.org ★ 281-719-9322 ext. 113 ★
www.inspirationranch.org
Physical Address: 25902 Glen Loch Drive, Spring, TX
Mailing: PO Box 130001, Spring, TX 77393

New Participant Registration

Date: _____

Participant Information:
Participant Name:_____Height:_____Weight:_____Date of Birth:_____
Address:_____City:_____Zip:_____
Preferred Phone:_____Alt. Phone: _____
Email:_____
Ethnicity: □ Caucasian □ African American □ Hispanic □ Asian □ Other:_____# of people in household_____

Parent/Guardian Information (if applicable):
Name:_____ Email: _____
Address (if different from above): _____ City:_____ Zip:_____
Home Phone:_____Cell Phone:_____

Caregiver Information (if applicable):
Name:_____ Email: _____
Home Phone:_____Cell Phone:_____

Emergency Information:
In case of emergency, please contact:
Name:_____ Relationship:_____Phone:_____
Name:_____ Relationship:_____Phone: _____

Physician's Name:_____Phone:_____
Preferred Medical Facility: _____
Health Insurance Company:_____Subscriber #:_____ Policy#_____

Liability Waiver:
I acknowledge the risks and potential for risks of equine assisted activities and therapies; However, I feel that the possible benefits to myself, my son, my daughter or my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Inspiration Ranch, its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I, my son, my daughter, or my ward may sustain while participating in the Inspiration Ranch Program.

WARNING: UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTICE AND REMEDIES CODE), A FARM ANIMAL PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN FARM ANIMAL ACTIVITIES RESULTING FROM THE INHERENT RISKS OF FARM ANIMAL ACTIVITIES.

Date:_____ Client or Parent/Guardian Signature:_____

Photo Release:
I □ DO □ DO NOT consent to and authorize the use and reproduction of any and all still and video photography of you/your child/ward for future publications, newsletters, presentations, social media, or any other uses for the benefit of Inspiration Ranch.
Client or Parent/Guardian Signature:_____Date:_____

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Participant Health History

Participant Name:_____ Gender: M F
Date of Birth: _____
Diagnosis(es):_____Date of Onset:_____Current
Medications:_____
Known side effects of Medication:_____
History of Seizures: Yes No ****if yes – additional forms required**
If yes, Seizure Type/Description:_____
Controlled: Yes No Date of last seizure: _____
Frequency of seizures:_____
Mobility (circle one): Independent Ambulation Assisted Ambulation Wheelchair
Braces/Assistive Devices: _____
Recent Surgeries: _____
Prospective Surgeries:_____
Therapy dog: Yes No
**if yes: 1) is the dog a service animal required because of a disability Yes No
2) what work or task has the dog been trained to perform_____
_____

Please indicate current or past special needs or areas of assistance needed in the following categories:

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Mobility			
Communication			
Heart			
Breathing/Respiratory			
Digestion			
Elimination			
Weight Gain/Loss			
Circulation			
Emotional/Mental Health			
Behavioral Health			
Pain			
Bone/Joint			
Muscular			
Cognition			
Allergies			
Addiction			
Fears/Phobias			
Loss or tragedy			

Client or Parent/Guardian Signature:_____Date: _____

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****To be completed by physician's office****

Physician Release

Participant Name:_____ Height:_____Weight:_____DOB:_____
Diagnosis(es):_____Date of Onset: _____
Current Medications: _____
Known side effects of Medication:_____
History of Seizures: Yes No **If yes: **Please provide seizure plan and release****
Seizure Type/Description:_____
Controlled: Yes No Date of last seizure:_____Frequency of seizures:_____
Shunt Present: Yes No Date of last shunt revision: _____
Recent/Prospective Surgeries: _____
Special Precautions/Needs:_____
For those with Downs Syndrome, a complete neurological exam has been completed and indicates no evidence of Atlanto Axial Instability or focal neurologic disorder: Yes Initial of Physician: _____

Please indicate current or past special needs in the following areas, including surgeries. These conditions may suggest precautions or contraindications to equine assisted activities.

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

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that Inspiration Ranch will weigh the medical information against the existing precautions and contraindications. Therefore, I refer this person to Inspiration Ranch for ongoing evaluation to determine eligibility for participation.
Name/Title:_____MD DO NO PA Other_____
Signature:_____License #_____Date: _____
Address:_____Phone Number: _____

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New Participant Profile

Date: _____

My full name is: _____

Please call me: _____

My birth date is: _____

I started riding at PCI Ranch: _____

I have _____ brothers, _____ sisters

My pets are: _____

My interest/hobbies are: _____

_____

My goals for Equine Assisted Therapy are: _____

_____

Optional: Please supply any details about the rider you think may be helpful to the volunteers who will be working with them.

Speech: _____ Comprehension: _____

Vision: _____ Hearing: _____

Ambulatory Status: _____

Other: _____

Particular methods that this rider responds to: _____

_____