River Valley Riders Emergency Contact and Liability Release Form

Equine Assisted Services at 2007 Neal Avenue South, Afton, MN

for _____Waldorf Schools________________________ on June 28, July 1, 12, 15, 2022_
School   Date(s)

Liability Release

____ (student's name) would like to participate in River Valley Riders (RVR). I acknowledge the risks and potential for risks of a horseback riding program. This activity will be conducted by RVR's PATH Intl. Certified Instructor; RVR volunteers; and school staff members. **I understand that under Minnesota law (statute 604A.12), RVR 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 accept the risk assumed and 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 RVR, the board of directors, instructors, therapists, volunteers and/or employees for any and all injuries and/or losses my child/ward may sustain while participating in RVR's program activities.

I certify that my child/ward is in good physical condition and is fully capable of participating in equine related activities such as horseback riding. I state that I will inform the RVR instructor of any limits with respect to his or her ability to safely engage in these activities by reviewing the reverse side of this form and answering additional questions if required. I also understand that the RVR instructor reserves the right to refuse any person assessed to be incapable of meeting the rigors and requirements of participating in equine related activities.

Age: ________ Height: ________ Weight: ________ Diagnosis: ______________________________

Signature: ____ Date: ________________
Parent or guardian

In Case of Emergency

Notify: ____ Phone: ____________________

Physician: ____ Phone: ____________________

Hospital: ____

List insurance carrier: ____

In case of emergency, I give permission for RVR to secure medical treatment including x-rays, surgery, hospitalization and medication.

Signature: ____ Date: ________________
Parent or guardian

Photo Release
I hereby consent to and authorize the use and reproduction to RVR of any and all photographs and any other audio-visual materials taken of me/my daughter/my son/my ward for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: ____ Date: ________________
Parent or guardian

For more information about RVR's programs and the benefits of equine assisted services, visit www.rivervalleyriders.org or call 651-439-2558.

Individuals with any of the below conditions require additional documentation to participate in therapeutic riding with RVR:

Medical/Psychological

Allergies
Physical/Sexual/Emotional Abuse
Cardiac Condition
Exacerbations of Medical Conditions
Hemophilia
Medical Instability
Migraines
Poor Endurance
Recent Surgeries
Substance Abuse
Animal Abuse
Blood Pressure Control
Dangerous to Self or Others
Fire Setting
Indwelling Catheters/Medical Equipment
Medications (e.g., photosensitivity)
Peripheral vascular disease (PVD)
Respiratory Compromise
Skin Breakdown
Thought Control Disorders

Orthopedic/Neurologic

Atlantoaxial Instability
Cranial Defects
Joint subluxation/dislocation
Osteoporosis
Spinal Joint Fusion/Fixation
Hydrocephalus/Shunt
Spina Bifida/Chiari II Malformation
Coxarthrosis
Heterotopic Ossification
Myositis Ossificans
Pathologic Fractures
Spinal Joint Instability/Abnormalities
Seizure
Tethered Cord/Hydromyelia

If any of the above conditions are present, we require that the parent/guardian complete the below medical history questions. We may contact you for more information.

Participant: ________________________ Diagnosis: ____________________

Parent Name(s): ____________________ Best phone number: ______________

Special Precautions/Needs: ____

Past/Prospective Surgeries: ________________ Medications: ________________

Seizure: ☐Yes ☐No Type: ___________ Controlled: ☐Yes ☐No Date of Last Seizure:_______________

Shunt Present: ☐Yes ☐No Date of Last Revision: ______________________________

Mobility: Independent Ambulation: ☐Yes ☐No Assisted Ambulation: ☐Yes ☐No Wheelchair: ☐Yes ☐No

Braces/Assistive Devices/Other Medical Equipment: ______________________________

For those with Down Syndrome: Neurologic Symptoms of Atlanto-Axial Instability: ☐Present ☐Absent

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Yes	No
Auditory		
Visual		
Tactile Sensations		
Speech		
Cardiac		
Circulatory		

	Yes	No
Integumentary/Skin		
Immunity		
Pulmonary		
Neurologic		
Muscular		
Balance		

	Yes	No
Orthopedic		
Allergies		
Learning Disability		
Cognitive		
Emotional/Psychological		
Pain		

If yes, comments: ____

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