SPIRIT
OPEN EQUESTRIAN PROGRAM INC.
www.spiritequestrian.org

Spirit Open Equestrian Program, Inc.
SpiritOEP@gmail.com
PO Box 1342
Great Falls, VA 22066

Dear Participant of Spirit Open Equestrian Program, Participant / Parent/Guardian,
Thank you for choosing our program as therapeutic or learning activity.

Welcome!

Please take a time to fill and submit following forms or bring them at your first session

We need you to submit, beside this Registration Form –mandatory for all participants:

- Waiver - available on line at our web site at http://spiritequestrian.org/forms.html - mandatory for all participants
- Participant Medical History and Physician's Statement – mandatory for participants in Equine Assisted Therapy (Therapeutic Riding Programs), or for anyone with medical condition which can interfere with program activities. Please, check and consult your physician regarding contraindications listed in form below.

Registration Form, Participant Medical History and Physician's Statement has to be filled and signed by you and your physician for each calendar year.

What are your goals for participating in SPIRIT Open Equestrian Program?

- Learning about Horsemanship and Equestrian skills
- Improving self esteem
- Improving trunk stability, muscular tone, posture, motor skills…
- Improving emotional, mental, social, skills and/or attitude
- Something else (use space below to describe, please)

Circle your program

1. Equine Assisted Learning with FCPA / beginner riding class
2. Equine Assisted Learning – Individual (pre teenage to young adults – 11-18 years old)
3. Equine Assisted Therapy - Therapeutic Riding with FCPA
4. Equine Assisted Therapy – Individual Therapeutic Riding
5. Equine Assisted Therapy – Equine Assisted Psychotherapy
6. Equine-Assisted Activity (other)

Thank you, with warm regards,

Davorka Suvak
Program Director
703-600-9667
www.spiritequestrian.org
http://spiritopenequestrian.blogspot.com/

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Participant Program Registration Form

Registration of: ____
(Printed full name of participant)

____
Age/DOB Weight Height

____
Full name of first parent / guardian Full name of second parent guardian

____
Address City Zip

____
Home # Cell # E-mail

PHOTO RELEASE

I as parent./guardian hereby grant Spirit Open Equestrian Program permission to interview ______________________ (participant's name) and/or to use my her/his in photograph(s) /video in any and all of its publications and in any and all other media, whether now known or hereafter existing. I will make no monetary or other claim against Spirit OEP or its staff for the use of the interview and/or the photograph(s)/video. This is a total release in perpetuity to any right, title or interest.

Parent/guardian name: __________________________ Signature: _____________________________

Participant's Authorization for 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 FPFP, I authorize The Spirit Open Equestrian Program Inc. to:

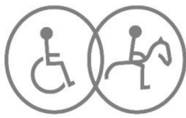
X Secure and retain medical treatment and transportation if needed.

X Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment at my expense.

I hold the Spirit Open Equestrian Program Inc. harmless for any expenses incurred in my interests.

Parent/guardian name: __________________________ Signature: _____________________________

Emergency Contact: ___________________________________Phone:____________________________
Physician's Name and Phone: ____
Preferred Medical Facility:____
Health Insurance Co.: ____
Policy #: ____ Group #:______________________________



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Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Print Name: ____

Phone: ____

Address: ____

Consent Signature: ________________________________ Date: ____________________

(Parent/Legal Guardian)

Non-Consent Plan

I do not give my 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. In the event emergency treatment/aid is required, I wish the following procedure to take place:

____

____

____

____

Non Consent Signature: ________________________________ Date: _________________

(Parent/Legal Guardian)

Parent/guardian name: ______________________ Signature: _________________________

Date:__________

Please, consult therapist about participation in EAA and add:

- available OT, PT, Speech Therapist suggestion
- any info you want to share about participant

Thank you,

Spirit Team
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