ENROLLMENT FORM

CARD
A Magical Connection

REGISTRATION
(Please notify us if your address or contact information has changed)

Rider: _____

Date of Birth: _____ **Diagnosis**: _____

E-mail: _____

By providing your email address you agree to have CARD contact you regarding upcoming events and registration.

Please list your class choices in order of preference for each term

Please refer to the class descriptions to help you make an appropriate decision. Riders will be placed as many times as they have requested, space permitting.

		CLASS TYPE	DAY AND TIME
FALL (Sept 24-Dec 8)	1		
	2		
Post date cheques: Sept 6/18 Nov 1/18	3		

		CLASS TYPE	DAY AND TIME
WINTER (Jan 7- Mar 9)	1		
	2		
Post date cheques: Dec 13/18 Feb 7/19	3		

		CLASS TYPE	DAY AND TIME
SPRING (Apr 1-Jun 8)	1		
	2		
Post date cheques: Mar 14/19 May 2/19	3		

Please note that registration forms may be returned in person, by fax, email or regular post. Payment(s) is due when placement is confirmed. A completed Medical Approval form is due by September 7th or your space will not be held.

Please note that by registering for classes, you are agreeing to abide by CARD's Rider Policy (available on the CARD website), and all its guidelines regarding rider enrollment or discharge; as well as class amendments and cancellations Please sign and date this form in the space provided below to indicate you have read this information.

Signature: _____ **Date:** _____

CONTINUING MEDICAL APPROVAL FORM

(To be completed and signed by the rider's physician)

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Rider:		
Diagnosis	**Height (cm)**	**Weight (kg)**
Date of last Tetanus Immunization	**Date of Birth:**	

Please note that for the physical well-being and safety of the CARD horses, volunteers and riders, the maximum weight of any rider must not exceed **160 pounds OR 73 kg**.

CHECK ALL THAT APPLY: The following conditions may be considered contraindications to therapeutic riding if present and may not be safe or beneficial in the therapeutic riding setting.

√	CONDITIONS	√	CONDITIONS
	Fused spine/ internal rigid spinal fusion devices		Osteoporosis and/or a history of fractures
	Herrington rod		Acute arthritis
	Scoliosis of 30 degrees or greater		An indwelling catheter
	Spinal cord paralysis above the mid-thoracic area		Experience vertigo or dizziness
	Spondylosthesis (vertebral dislocation with acute pain)		Open pressure sores on weight- bearing areas
	Prolapsed or herniated inter-vertebral disc		Increased blood pressure
	Subluxation, dislocation, or degeneration of the hip		Heart condition or ever experience chest pains
	Seizures Type of Seizure: Are your seizures controlled by medication? Date of last seizure:		Allergies If yes, do you carry an Epipen?

CHANGES OBSERVED IN THE PAST YEAR	**Y/N**	**CHANGES OBSERVED IN THE PAST YEAR**	**Y/N**
General Health		**Physical Status**	
Medications		**Surgical Procedures**	
Neurological Status		**Radiography or Symptoms** of Atlanto-Axial Instability (for riders with Down Syndrome only)	
If you answered YES to any of the above please provide details:			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic center will weigh the medical information above against existing therapeutic riding precautions and contraindications. Assessment of this person's abilities/limitations for the purpose of implementing an effective equestrian program is the responsibility of the center.

SIGNATURE: _____ DATE: _____

Physician

Please Print Name: _____