

## ENROLLMENT FORM



### 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.

FALL (Sept 23-Dec 7)		CLASS TYPE	DAY AND TIME
	1		
	2		
	3		

Post date cheques:  
Sept 5/19  
Nov 4/19

WINTER (Jan 6- Mar 14)		CLASS TYPE	DAY AND TIME
	1		
	2		
	3		

Post date cheques:  
Dec 12/19  
Feb 6/20

SPRING (Apr 6-Jun 13)		CLASS TYPE	DAY AND TIME
	1		
	2		
	3		

Post date cheques:  
Mar 19/20  
May 7/20

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 6th 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)

<b>Rider:</b>		
<b>Diagnosis</b>	<b>Height (cm)</b>	<b>Weight (kg)</b>
<b>Date of last Tetanus Immunization</b>	<b>Date of Birth:</b>	

**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.

<input type="checkbox"/>	CONDITIONS	<input type="checkbox"/>	CONDITIONS
<input type="checkbox"/>	Fused spine/ internal rigid spinal fusion devices	<input type="checkbox"/>	Osteoporosis and/or a history of fractures
<input type="checkbox"/>	Herrington rod	<input type="checkbox"/>	Acute arthritis
<input type="checkbox"/>	Scoliosis of 30 degrees or greater	<input type="checkbox"/>	An indwelling catheter
<input type="checkbox"/>	Spinal cord paralysis above the mid-thoracic area	<input type="checkbox"/>	Experience vertigo or dizziness
<input type="checkbox"/>	Spondylosthesis (vertebral dislocation with acute pain)	<input type="checkbox"/>	Open pressure sores on weight-bearing areas
<input type="checkbox"/>	Prolapsed or herniated inter-vertebral disc	<input type="checkbox"/>	Increased blood pressure
<input type="checkbox"/>	Subluxation, dislocation, or degeneration of the hip	<input type="checkbox"/>	Heart condition or ever experience chest pains
<input type="checkbox"/>	Seizures Type of Seizure: Are your seizures controlled by medication? Date of last seizure:	<input type="checkbox"/>	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)	
<b>If you answered YES to any of the above please provide details:</b>			

**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: \_\_\_\_\_  
Physician

DATE: \_\_\_\_\_

Please Print Name: \_\_\_\_\_