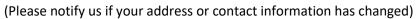
## **ENROLLMENT FORM**

## **REGISTRATION**





oate of Birth:	Diagnosis:
hone:	E-mail:
By providing your em	ail address, you agree to have CARD contact you regarding upcoming events and registration.
P	ease note that we are only taking registration for Fall 2020 at this time.
_	<b>e:</b> Riders whose Spring 2020 enrollment was deferred to Fall 2020 are asked to return this form by to confirm their placement. After August 24 <sup>th</sup> any open spaces remaining will be offered to riders tion criteria.
FALL (Sept 21-Dec 5)	1 Spring 2020 rider: I will attend my original Spring term day/time
Post date	2 Spring 2020 rider: I need a new class day/time, as my availability changed
cheques: Sept 4/20 Nov 6/20	3 I want to register for Fall 2020 once the deadline passes but was not a Spring 2020 rider. Please let me know my class options.
☐ I will wear ba☐ I understand☐ I will complet☐ I will abide by☐ I will abide by☐ I understand☐ I understand☐	nask in the facility and while riding rrier gloves, or agree to sanitize my hands before mounting the horse am responsible for providing my own mask and gloves each week e a health survey each week upon entering to the facility social distancing guidelines when I am not riding the amended arrival and departure times only one person may accompany me when I attend CARD classes that my safe participation in classes relies on my compliance with all safety protocols and that my II be suspended if I am unable/unwilling to comply with the required protocols.
	ents will be in two installments. If you already remitted payment for Spring 2020 and left the fees it towards the Fall 2020 fees.
-	gistering for classes, you are agreeing to abide by the above criteria, as well as CARD's Rider Polic D website) Please sign and date this form in the space provided below to indicate you have read
ignature:	Date:

## **CONTINUING MEDICAL APPROVAL FORM**

Type of Seizure:

Date of last seizure:

Are your seizures controlled by medication?

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



COVID-19 Amendment- we request this form be completed by a physician, however, we will accept the information being provided by a client or parent until a doctor is available. Please ensure the WEIGHT is current and accurate.

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** ٧ ٧ 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 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.

PHYSICIAN SIGNATURE:	DATE:
Please Print Name:	