

Rider Application and Health History

(PLEASE PRINT)

Current date: 9/28/2010

Participant's Name:

Date of Birth: Male/Female: Age: Weight: Height:

Parent or Guardian:

Address: City: State: Zip:

Home Phone: Work Phone (list owner):

Mom's Cell: Dad's Cell: Guardian's Cell:

Email address:

Note: Complete the following only when parent/guardian is **NOT** the contact person:

Contact Name: Relationship:

Home Phone: Work Phone: Cell:

<p>Optional:</p> <p>Family Gross Income Level: \$ 9,000 to 15,000 <input type="checkbox"/> (select one) \$15,001 to 24,000 <input type="checkbox"/> \$24,001 to 45,600 <input type="checkbox"/> \$45,601 and up <input type="checkbox"/></p> <p>Receive government financial assistance? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Indicate one:</p> <p>1) White <input type="checkbox"/> 2) Black <input type="checkbox"/> 3) Asian <input type="checkbox"/> 4) Hispanic <input type="checkbox"/> 5) Other (list heritage) <input type="text"/></p> <p># of Members in Family: <input type="text"/></p> <p>Veteran? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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Participant's Disability (required):

Date of Onset:

HEALTH HISTORY:

Parent/Guardian: please list current or past physical, emotional, or mental conditions that require consideration when the applicant is participating in any equine related activity - including, but not limited to, riding, handling horses, etc. Please be specific. For example: 'limited or no vision in right eye', 'brace on left ankle', 'uncontrollable outbursts of anger', 'fear of heights/animals/horses', 'allergic reaction to dust/animal dander', 'onset of seizure indicator', 'rods in back', 'shunts in use', etc.

NOTE: Regardless of your physician's permission/release, the final decision for participation in equine related activities rests with MVT's Program Coordinator.

MEDICAL INFORMATION:

Physician's Name:

Phone #:

Physician's Address:

Medical Insurance Co.:

Policy #:

MEDICATIONS:

What medications is participant currently taking, including over the counter medications? (Please update promptly when medications are added or changed).

AMBULATORY STATUS (please describe):

EMERGENCY CONTACT:

Person who is authorized to give temporary assistance or care in absence of parent or guardian:

Name:

Phone #:

Relationship:

Are there any medical conditions that require special precautions or treatment:

I. Yes, please describe below:

II. None:

EMERGENCY MEDICAL RELEASE:

In case of a **Medical Emergency**, the undersigned authorizes **Mesa Vista Therapeutics, Inc.** to provide such medical assistance as they determine to be necessary.

In the event that the preferred physician (listed above) cannot be reached, the undersigned authorizes any medical, surgical care, and/or hospital staff to provide care, including anesthetic, for the participant which they determine necessary or advisable, pending receipt of a specific consent from the undersigned.

No rider can be accepted for riding instruction until this form has been completed by the Parent/Parents or Guardian/Guardians. If the rider is of legal age (18), he or she may complete the form, if he or she is legally competent to do so.

Yes, I would like
have discussed this with the doctor.

to have riding/driving instruction and

SIGNATURE OF CLIENT **IF LEGAL AGE (18):**

SIGNATURE OF PARENT OR GUARDIAN **IF UNDERAGE:**

Print name of parent or guardian:

Mesa Vista Therapeutics, INC.

Please read and sign both sections.

!!WARNING!!

AN EQUINE ACIVITY SPONSOR OR EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO, OR THE DEATH OF, A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES.

LIABILITY RELEASE AGREEMENT

_____ (**Client's Name**) would like to participate in the **Mesa Vista Therapeutics, Inc.** riding program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself / my son / my daughter / my ward are greater than the risk assumed. 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 **Mesa Vista Therapeutics, Inc.**, its Board of Directors, personnel/volunteers, for any and all injuries and / or losses I / my son / my daughter / my ward may sustain while participating in riding at **Mesa Vista Therapeutics, Inc.**

Date:

Signature:

(Client, Parent or Guardian)

PHOTO RELEASE

I **Do**

I **Do NOT**

consent to and authorize the use and reproduction by **Mesa Vista Therapeutics, Inc.** of any and all photographs and any other audiovisual materials taken of me / my son / my daughter / my ward for promotional printed material, educational activities, or for any other use for the benefit of **Mesa Vista Therapeutics, Inc.**

Date:

Signature:

(Client, Parent or Guardian)