



**CTR****H**

Cincinnati Therapeutic  
Riding and Horsemanship

1342 U.S. Highway 50 • Milford, OH 45150

Phone: 513-831-7050 • Secure Fax: 844-716-2708 [www.ctrhohio.org](http://www.ctrhohio.org)

## RIDER INFORMATION AND CONSENT FORM

### Participant Information

Participant Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_

How did you hear about CTRH? \_\_\_\_\_

\_\_\_\_\_

### Emergency Contact Information

#### Emergency Contact #1

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

#### Emergency Contact #2

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

## Physician Information

Physician Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

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## Insurance / Third-Party Funding

Is there a Third-Party Payer (CCDD, etc.)?

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Do you receive Medicaid?

Yes  No

If yes, type of Medicaid:

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## Emergency Medical Consent

In the event emergency medical aid or treatment is required due to illness or injury while receiving services or while on the property of Cincinnati Therapeutic Riding and Horsemanship, I authorize CTRH to:

1. Secure and retain medical treatment and transportation if necessary.
2. Release records upon request to authorized individuals or agencies involved in emergency treatment.

## Consent Plan

This authorization includes x-rays, surgery, hospitalization, medication, and any treatment procedure deemed life-saving by a physician. This provision will only be used if the emergency contact person cannot be reached.

## Signature of Rider/Parent/Guardian/Caregiver

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# Non-Consent Plan

I do not give consent for emergency medical treatment or aid in the event of illness or injury while receiving services or while on the property of CTRH.

If emergency treatment becomes necessary, I request the following procedures:

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Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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# Participant Information

**Does the participant have any fears we should know about?**

(Examples: falling, heights, animals, etc.)

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**Does the participant have a history of animal abuse?**

No

Yes (please explain)

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**Medical conditions relevant in an emergency**

(Examples: allergies, bee stings, heart conditions, etc.)

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## Additional Information

Please list any information that would be helpful for instructors and volunteers. Returning riders should note any changes such as medications, surgeries, or other important updates.

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## RELEASE OF LIABILITY

I, \_\_\_\_\_, as the rider, parent, or legal guardian of a rider, wish to participate in the Cincinnati Therapeutic Riding and Horsemanship Program.

I acknowledge that risks are inherent in horseback riding and equine activities. I believe the benefits to myself/my child/my ward outweigh those risks.

I hereby waive, release, and discharge Cincinnati Therapeutic Riding and Horsemanship, its Board of Directors, officers, instructors, therapists, aides, volunteers, independent contractors, and employees from any and all liability, damages, and claims arising from participation in CTRH activities.

I understand the inherent risks of equine activities include, but are not limited to:

- A. The natural behavior and unpredictability of horses.
- B. Reactions to sounds, sudden movements, unfamiliar objects, people, or animals.
- C. Surface and subsurface hazards.
- D. Collisions with horses, animals, people, or objects.
- E. Negligent actions by participants that may contribute to injury, death, or loss.

I certify that I have had sufficient opportunity to read and understand this Voluntary Waiver and Release Agreement and ask questions if needed.

Participant Signature: \_\_\_\_\_

Parent/Guardian/Caregiver (if participant is a minor):

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Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# PHOTO RELEASE

I:

DO CONSENT

DO NOT CONSENT

to the use and reproduction by Cincinnati Therapeutic Riding and Horsemanship of photographs and other visual materials of myself/my child/my ward for promotional materials, educational purposes, and other uses benefiting the program.

Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## PARTICIPANT DEMOGRAPHIC INFORMATION

The following information is confidential and used solely for anonymous reporting required by grant funders and philanthropic supporters.

Participant Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Age: \_\_\_\_\_

Gender:

Male

Female

County and State of Residence:

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Diagnosis:

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When did the participant first begin attending CTRH?

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## Ethnicity

- White/Caucasian
  - Black/African American
  - Hispanic Origin
  - Asian/Pacific Islander
  - American Indian
  - Other: \_\_\_\_\_
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## Household Income

- Less than \$25,519
  - \$25,520–\$34,479
  - \$34,480–\$43,439
  - \$43,440–\$52,399
  - \$52,400–\$61,359
  - \$62,360–\$70,319
  - \$70,320–\$79,279
  - \$79,280–\$88,239
  - \$88,240–\$99,999
  - \$100,000+
  - Prefer Not to Answer
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Total Number in Household: \_\_\_\_\_

Number of Household Members Under Age 19: \_\_\_\_\_

# Employment Information

Parent/Guardian Occupation:

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Employer:

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Does your employer offer a matching gift program?

Yes  No

Would you consider requesting a matching gift for CTRH?

Yes  No

Does your employer provide grants or sponsorships to nonprofits?

Yes  No

Would you consider working with CTRH to request support from your employer?

Yes  No

If yes, please provide your contact information:

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## Form Completion

Form Completed By:

Self

Parent/Guardian

Spouse

Aide

Date Completed:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_