Sojourn Therapeutic Riding Center, 501(c)(3)
24861 S. 88th Avenue, Frankfort, IL 60423
708.539.3078

Physician's Statement

(To be filled out completely by the Participant's medical doctor)

Participant:	**DOB:**	**Height:**	**Weight:**
Primary diagnosis:			
Secondary diagnosis:			
Past/Prospective surgeries:			
Medications:			
Seizure type:	N/A	Controlled: Y N	Date of last seizure:
Shunt present:	N/A Y N		Date of last revision:
Special precautions/needs:			
Independent ambulation: Y N	Assisted Ambulation: Y N		Wheelchair Y N
Braces/Assistive Devices:			
For those w/ Down Syndrome: AtlantoDens Internal X-rays, date:			Result: + -
Neurological symptoms of AtlantoAxial Instability:			

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in therapeutic riding sessions under the instruction of a NARHA registered instructor.

Name/Title (print)_____

Signature:_____Date:_____

Address_____

Phone: ( )_____

Sojourn Therapeutic Riding Center, 501(c)(3)
Authorization for Emergency Medical Treatment

Name:	D.O.B.	Phone: ( )
Address:	City:	Zip:
Physician's Name:		
Health Insurance Co:	**Policy #:**	
Allergies to medications:		
Other Allergies:		
Current medications:		

In the event of an emergency, contact:

Name	**Relation**	**Phone**

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving or giving services, or while being on the property of the agency, I authorize Sojourn Therapeutic Riding Center, Ltd. to:

1. Secure and retain medical treatment and transportation if needed,
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

CONSENT PLAN

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date:_____Consent Signature:_____

Client, Parent or Legal Guardian

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving or giving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following to take place:

_____
_____
_____
_____

Date:_____ Consent Signature:_____

Client, Parent or Legal Guardian

Sojourn Therapeutic Riding Center, 501(c)(3)
Participant's Application

Participant			
Parent(s)/Legal Guardian(s)			
D.O.B.	Age:	Weight:	M/F
Address:			
City:		State:	Zip:
Phone: ( )		Alternative Phone: ( )	
Email address:			
Occupation (father):		Employer:	
Occupation (mother):		Employer:	
Work phone (father): ( )		Work phone (mother): ( )	
Occupation (participant)		Employer/School	
Work phone (participant): ( )			
Referred by:			

PHOTO RELEASE

☐ I DO ☐ I DO NOT

Consent to and authorize the use and reproduction by Sojourn Therapeutic Riding Center, Ltd. of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions, or for any other use for the benefit of the program.

Signature:_____Date:_____
Client, Parent, or Legal Guardian

LESSONS/FEE

Participants are assigned to ½ hour instructional time. It is recommended that participants arrive 10 minutes early to put on their helmets, vests or safety belts. Lessons are paid in a 6 session block. Sojourn does not reschedule missed lessons, so please make every effort to maintain your lesson time/block. In the event a lesson is missed, the block still must be paid and a make-up lesson will **not** be scheduled. If Sojourn must cancel a lesson, the fee will either be reimbursed or forwarded to the next block.

Lessons will proceed in the following manner so as to serve the best interest of all involved, including the horse: 30 minute specific lesson plan including mount and dismount. There may be times when the lesson will focus on grooming if an issue of safety per the horse or rider should occur, or if the client indicates a desire to groom versus ride or wishes to do both within the designated time frame.

We offer group and private lessons:
Group lessons are $210 per block.

Private lessons are $420 per block.

Lessons are paid in advance for a block of 6 sessions.

All students are evaluated before riding and being assigned a horse. Assessment fee (one time only fee for new clients) is $75.00

Lesson fees are subject to change.

Sojourn Therapeutic Riding Center, Inc. 501(c)(3) Contract
Barbara R. Mulry, Owner/Trainer
24861 S. 88th Avenue
Frankfort, IL 60423
708.539.3078
bmulry@gmail.com

I, _____, agree to services rendered by Barbara R. Mulry to ride and train under Sojourn Therapeutic Riding Center. I agree to hold harmless Barbara R. Mulry (owner/trainer), Sojourn Therapeutic Riding Center, Inc. NFP, and all constituencies of Sojourn Therapeutic Riding Center, from all claims in addition to the statement below**.**

Release of Liability: ADDITIONALLY, in consideration of Sojourn Therapeutic Riding Center NFP, I do agree to hold harmless and release Sojourn Therapeutic Riding Center, NFP (its owners, agents, employees, officers, directors, representatives, assigns, members, affiliate organizations, insurers, and others acting on said facility's behalf), and Barbara R. Mulry (owner/trainer) of all claims, demands, causes of action and legal liability, whether the same be known or unknown, anticipated or unanticipated, due to ordinary negligence; and I further agree that, except in event of gross negligence and willful and wanton misconduct, I shall not bring any claims, demands, legal actions, and causes of action against those listed above in this clause, for any economic or non-economic losses due to bodily injury, death, and/or property damage**. I understand that the art of equitation can be dangerous and may potentially cause injury and/or death. I understand that equines are animals that can be unpredictable. I knowingly accept this risk**. **In regard to a minor, I knowingly accept this risk for my child.** I agree to wear appropriate riding attire, **including a helmet**, at all times.

WARNING: Under the equine activity liability act, each participant who engages in an equine activity expressly assumes the risk of engaging in and legal responsibility for injury, loss or damage to person or property, resulting from the risk of equine activities.

I have read, and *understand* all of the conditions listed above. I have reviewed and agreed upon the conditions listed above. Should any violations of the contract occur, the contract will be immediately revoked.

Concerning a minor: I have read and explained the meaning of this contract to my child (**for children 12 and over). I take full responsibility for making this decision for my child and signing this contract on my child's behalf (all children under age 18).**

_____ _____
Rider Signature (all riders over the age of 12) Date

_____ _____
Parent/Guardian Signature (if applicable) Date

_____
Street address City State Zip Code

_____
Phone #s and Email