Rein-Bow Riding Academy
A service of the Therapy & Learning Center

Dear Caregiver,

Thank you for your interest in this very special program. We offer both hippotherapy and therapeutic riding at the Rein-Bow Riding Academy. Children and young adults with developmental delays may benefit from equine-assisted activities.

The program is held an indoor arena in Huron, TN. During a 45 minute session, riders will spend time on horseback and also doing ground activities such as grooming the horse. Hippotherapy sessions are one-on-one sessions, and therapeutic riding may be individual lessons or small groups of students riding together. All sessions are on Tuesdays between 4:15 and 8:00 pm; see application for specific times. There are three riding sessions early spring, late spring/early summer, and fall.

Applications are due by the first Friday in February. Each application includes a portion to be completed by you, and also a form that must be completed by your child's physician. An application is complete when both sections have been received. Our team of instructors will then complete clinical review of applications and you will be contacted shortly afterward.

All riders in the program are able to participate at no cost to families. Staff, volunteers, and families work very hard throughout the year to raise money to cover the program expenses. We are very blessed to have such a dedicated group of supporters.

If you have questions, please feel free to contact us using the information below.
There is also a dedicated Facebook page.

Sincerely,

Reinbow Riding Team
34 Garland Dr.
Jackson, TN 38305

731-664-3670

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Rider Application Form
Riding Season Year _____

Participant: _____

Date of Birth: _____ Age: _____ Gender: M F Height: _____ Weight: _____

Address: _____City:_____ State: _____ Zip: _____

Parent/Guardian(s): _____

Home phone: _____ Cell phone(s): _____

Work phone: _____ E-mail: _____

In case of emergency: Contact: _____ Phone: _____

Contact: _____ Phone: _____

Physician(s): _____

Diagnosis: _____

School attending: _____ Grade: _____

How did you find out about the program? _____

Does your child receive any therapy services? If so, please describe: _____

Goals (i.e., what would you like to gain from this experience?): _____

_____

_____

Please number the session dates in order in which you would prefer:

☐ Session 1 (Spring) ☐ Session 2 (Summer) ☐ Session 3 (Fall)

Please check all session times when your child is available to participate in lessons:

☐ 4:15 – 5:00 pm ☐ 5:00 – 5:45 pm ☐ 5:45 – 6:30 pm ☐ 6:30 – 7:15 pm ☐ 7:15 – 8:00 pm

Signature: _____ Date: _____

Note: Should the physical condition of the participant change at any time, a new physician's referral form must be completed. Any surgeries or change in medication must be reported immediately. Contact your instructor for additional forms.

For office use only: Full packet obtained on: _____

Rein-Bow Riding Academy
Release and Indemnity Agreement Year _____
Parent/Guardian of Participants

The undersigned, as parent/parents or guardian of _____,
a minor, for and in consideration of the agreements of Rein-Bow Riding Academy and Therapy & Learning Center to provide riding instructions, facilities and horses to the said minor, does/do hereby forever release, acquit, discharge, indemnify and hold harmless Rein-Bow Riding Academy and the Therapy & Learning Center, its officers, directors, trustees, agents, employees, representatives, successors and assigns and including all volunteers assisting them, for all manner of claims, demands, suits and damages of every kind and nature, which the undersigned or the said minor may have against Rein-Bow Riding Academy and the Therapy & Learning Center, its officers, directors, trustees, agents, employees, representatives, successors, or assigns, or volunteers on account of any personal injuries, physical or mental condition, known or unknown, to the undersigned or the said minor, or the treatment thereof or any other damage arising as a result of or in any way connected with the acts of Rein-Bow Riding Academy and Therapy & Learning Center, its officers, directors, trustees, agents, employees, volunteers, successors or assigns, including, but not limited to, their negligence or gross negligence in rendering the services above described or in any way incidental thereto, including, but not limited to, the providing of any animals for such riding instruction, therapy, or riding.

If any provision of the Release Agreement shall be deemed invalid or unenforceable under applicable law, such provision shall be ineffective only to the extent of such prohibition or invalidity, without invalidating the remainder of such provision or the remaining provision of the agreement.

WARNING

Under Tennessee law, an equine professional is not liable for injury or death of a participant in equine activities resulting from the inherent risk of equine activities, pursuant to Tennessee Code Annotated, Title 44, Chapter 20, Section 1.

Printed Rider Name: _____

Rider Signature (when appropriate): _____

Parent/Guardian Name **Printed**: _____

Parent/Guardian **Signature**: _____

Date: _____

Rein-Bow Riding Academy/Therapy & Learning Center
Authorization for Emergency Medical Treatment Form Year_____

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current medications: _____

In the event of emergency contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Consent Plan
In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Rein-Bow Riding Academy to:

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

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 services or while being on the property of the agency.

☐ Parent or legal guardian will remain on site at all times during equine-assisted activities.
☐ In the event emergency treatment/aid is required, I will the following to take place:

_____
_____
_____

Date:_____ Non-Consent Signature:_____
Client, Parent or Legal Guardian

Rein-Bow Riding Academy/Therapy & Learning Center

Consent to Photograph Year _____

I, _____, hereby grant and assign to Jackson-Madison County General Hospital District and/or West Tennessee Healthcare ("WTH") a non-exclusive, royalty-free license to use any and all photographs, videotapes, digital images, and audio recordings taken of me and/or child by or for representatives of the system. I understand and agree that this material may be used in one or all of the following:

Radio / Television Broadcasts

Newspaper / Magazine Articles

Print Materials / Advertisements

Web Site / Internet

This consent will not expire until such time as the District and/or WTH no longer desires to use or disclose the information described above for the general purposes for which this consent was obtained. You may revoke this consent, and if you wish to do so, you may send a letter to the Privacy Coordinator, West Tennessee Healthcare, 620 Skyline Drive, Jackson, TN 38301.

Signature: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Witness: _____

REIN-BOW RIDING ACADEMY/THERAPY & LEARNING CENTER
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
(MARKETING/PUBLIC RELATIONS)

NAME:	**Date of Birth:**	**SS No. (optional)**
ADDRESS:	**RELEASE PROTECTED HEALTH INFORMATION TO:**	
TELEPHONE:	**JACKSON-MADISON COUNTY GENERAL HOSPITAL DISTRICT; THERAPY & LEARNING CENTER**	

INFORMATION BEING RELEASED BY:

Purpose of Disclosure: ☐ At the Request of the Individual Identified Above
☒ Media, Public Relations, Marketing, Advertising, Posting, or Radio or Television Broadcasting
☒ Other, Please Explain: Fundraising Activities

Description of Information to be Used or Disclosed: __X_ Photographs/Video of me and/or my child
____ Other (specify):

I understand that:

1. I may revoke this authorization in writing at any time, but if I do so, it will not have any effect on any actions taken by the facility releasing the information (hereafter referred to as "the facility") prior to the facility's receiving the revocation. Further details regarding the manner in which this authorization may be revoked may be found in the facility's Notice of Privacy Practices.
2. This authorization allows the facility to release the above requested documents. The released information may no longer be protected by federal privacy regulations and may be redisclosed.
3. The facility is hereby released from any liability and the undersigned will hold the facility harmless for complying with this authorization.
4. The facility will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization, except for research related purposes and as otherwise permitted under applicable law.
5. The authorization will not expire until such time as the facility no longer desires to use or disclose the information described above for the general purposes for which this authorization was obtained.
6. If the facility will use or disclose my protected health information for marketing purposes, the facility will not receive remuneration or compensation for such use or disclosure for marketing purposes unless the WTH Privacy Coordinator completes and signs the following statement:

I, _____ (signature of WTH Privacy Coordinator) hereby certify that the facility will receive remuneration or compensation for the use or disclosure of this patient's protected health information from _____ (fill in source of remuneration or compensation).

I have read and understood this authorization. I hereby authorize the use and disclosure of the above-requested protected health information.

_____ _____

Signature **Signature of Authorized Representative**

_____ _____

Date **Description of Representative's Authority to Act for Individual**