



**PEGASUS**  
 Therapeutic Riding Center  
*All Special Needs, All Ages*  
 501(c)(3) Non-profit Tax ID:95-3774003

## CLIENT / RIDER APPLICATION

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
 PRINT Applicant's Name

### Attends What School?

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To apply as a client at Pegasus Therapeutic Riding for the disabled, the enclosed application must be completely filled out to be accepted. This information is necessary for the client's safety. Applications not completed will be returned.

The client will be scheduled into a class when the application is approved and /or an opening becomes available. No applicant will be allowed on a horse until the application is received and approved.

Enclosed you will find the following: **Signatures are required.**

\_\_\_\_\_REGISTRATION

\_\_\_\_\_PHYSICIAN REFERRAL – **Need Doctors SIGNATURE AND OFFICE STAMP**

\_\_\_\_\_LIABILITY RELEASE

\_\_\_\_\_AUTHORIZATIN TO TREAT MINORS / ADULTS

\_\_\_\_\_PHOTO RELEASE

FILL OUT THIS FORM, AND RETURN COMPLETED TO THE MAILING ADDRESS BELOW.

**Should you have any further questions, please leave a message at Pegasus Stables / Office. One of our staff will contact you. The phone number is: 760- 772-3057.**

MAILING ADDRESS: P.O. BOX 13508, Palm Desert, CA. 92255  
 FACILITY LOCATION: Desert Hot Springs CA 92241

**NON-PROFIT 501 (C) (3) CORPORATION FEDERAL TAX ID 95-3774003**  
[www.PegasusCV.org](http://www.PegasusCV.org)



# REGISTRATION

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

Applicant's Name (print) \_\_\_\_\_ Age: \_\_\_\_\_

ATTENDS WHAT SCHOOL? \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Cell Phone: \_\_\_\_\_ Home: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

Parent / Guardian Authorization: Print: \_\_\_\_\_ Signature \_\_\_\_\_

Parent/ Guardian Employer: \_\_\_\_\_

## INSURANCE INFORMATION

Insurance: \_\_\_\_\_

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

Medicare Number: \_\_\_\_\_ Medical Number: \_\_\_\_\_ Certificate Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Code: \_\_\_\_\_

## MEDICAL INFORMATION

Physician's Name (Print) \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Disability: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies to food, drugs, or animals: \_\_\_\_\_ Last Tetanus Toxoid Booster: \_\_\_\_\_

Special Medical Conditions (feeding tubes, shunts, hearing aids) etc. \_\_\_\_\_

\_\_\_\_\_

## PARENT OR GUARDIAN DAYTIME CONTACT NUMBERS: WORK OR HOME OR CELL

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

**Pegasus Therapeutic Riding PO Box 13508, Palm Desert, CA 92255, Phone: 760.772.3057**



DATE: \_\_\_\_\_

**MUST BE FILLED OUT AT THE DOCTORS OFFICE WITH PHYSICIAN'S SIGNATURE AND STAMP ON NEXT PAGE  
IN ORDER FOR YOU OR YOUR CHILD TO RIDE.**

**APPLICANT / PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **AGE** \_\_\_\_

**SEX:** \_\_\_\_\_ **HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_ **PULSE:** \_\_\_\_\_ **B.P.:** \_\_\_\_\_

**DIAGNOSIS** \_\_\_\_\_

**CAUSE:** \_\_\_\_\_

**MEDICATIONS (Type, Purpose, Dose):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If Downs Syndrome, Atlanto-Axial Subluxation? Yes / No

Cervical X-Ray for Atlanto-Axial Subluxation: Positive \_\_\_ Negative \_\_\_ X-ray Date: \_\_\_\_\_

Tetanus Shot: Yes / No Date \_\_\_\_\_

**MOBILITY STATUS:**

Ambulatory? Yes / No

Can the patient ambulate independently Yes / No

If No, Describe: \_\_\_\_\_

**PROSTHETICS / ORTHOTICS:**

Type: \_\_\_\_\_ Purpose: \_\_\_\_\_

Type: \_\_\_\_\_ Purpose: \_\_\_\_\_



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

**Please describe any other additional information that might help us to work with this Applicant/Patient**

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Please indicate if the Applicant/Patient has a history of the following secondary problems by checking yes or no. If YES, please include COMPLETE information pertaining to the problem.

<b>PROBLEM</b>	<b>Yes</b>	<b>No</b>	<b>IF YES, History of, Describe</b>
Auditory Impairment	_____	_____	_____
Learning Disability	_____	_____	_____
Mental Impairment	_____	_____	_____
Psychological Impairment	_____	_____	_____
Speech Impairment	_____	_____	_____
Visual Impairment	_____	_____	Glasses: _____
Allergies	_____	_____	_____
Cardiac	_____	_____	_____
Circulatory PVD	_____	_____	_____
Postural Hypotension	_____	_____	_____
Hemophilia	_____	_____	_____
Asthma/COPD	_____	_____	_____
Neurological			
Seizures	_____	_____	Controlled Last _____
Hydrocephalus	_____	_____	Seizure: _____
Shunt, if yes, where?	_____	_____	_____
Sensory Loss	_____	_____	_____
Pain	_____	_____	_____
Muscular Contractures	_____	_____	_____
<b>SKELETAL</b>			
Heterotrophic Ossification	Y	N	_____
Spinal Column Injury	Y	N	_____
Subluxing Joints	Y	N	_____
Joint Disease	Y	N	_____
Dislocating Joints	Y	N	_____
Laminectomy/Fusion	Y	N	_____
Scoliosis	Y	N	_____
Brace	Y	N	_____
Kyphosis/Lordosis	Y	N	_____
Cranial Defects	Y	N	_____
Fractures	Y	N	_____
Spondylolisthesis	Y	N	_____
Spinal Abnormality	Y	N	_____
Osteoporosis	Y	N	_____



**MEDICAL  
HISTORY  
CONTINUED**

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

Please indicate any medical problems not indicated on pages 2 & 3:

\_\_\_\_\_

Please indicate special precautions:

\_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name: (Please Print) \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**PHYSICIAN'S STAMP**

**PHYSICAL THERAPY ASSESSMENT IF APPLICABLE:**

PATIENT: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ School Placement \_\_\_\_\_

Disability: \_\_\_\_\_ Ambulatory: Y/ N\_ Muscle Tone: \_\_\_\_\_

Sensation: \_\_\_\_\_ Rom Limitations: \_\_\_\_\_

Balance / Equilibrium: \_\_\_\_\_ Other Structural Abnormalities: \_\_\_\_\_ Equipment: \_\_\_\_\_

Evaluation Summary \_\_\_\_\_ Precautions or Restrictions \_\_\_\_\_

Suggested Exercises: \_\_\_\_\_ Physical Therapist (Names) \_\_\_\_\_

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

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



**LIABILITY RELEASE**

**SIGNATURES REQUIRED FOR EACH (3)  
WAIVER / RELEASES BELOW**

**APPLICANT:** (Print Name) \_\_\_\_\_

This Applicant is represented for all releases and waivers as follows below. To participate in the Pegasus program, I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to me / 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 Pegasus, and its Board of Directors, Instructors, Therapists, Aides, Volunteers and / or Employees for all injuries and / or Losses I / my son / my daughter / my ward may sustain while participating in Pegasus.

Print Name: \_\_\_\_\_ **Signature:** \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION TO TREAT A MINOR or ADULT CLIENTS**

I / WE, the undersigned applicant, parent, parents or legal guardian of Client / Rider named above, a minor or adult, do hereby authorize and consent to any X-ray examination, anesthetic, medical or surgical diagnosis rendered under general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act, a Dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute General Hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the physician in the exercise of his best judgment may deem advisable. It is understood that every effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions: \_\_\_\_\_

Print Name: \_\_\_\_\_ **Signature:** \_\_\_\_\_ Date: \_\_\_\_\_

**Circle Relationship to Applicant:** Self, Father, Mother, or Legal Guardian

**This Liability Release remains in effect until an updated release is received.**

**EMERGENCY CONTACT NUMBERS: IN CASE OF A DAYTIME EMERGENCY PLEASE CALL**

**PRINT NAME:** \_\_\_\_\_ **CELL:** \_\_\_\_\_ **PRINT NAME:** \_\_\_\_\_ **CELL:** \_\_\_\_\_

**PHOTO RELEASE**

For valuable consideration given and which is hereby acknowledged, the undersigned grants to Pegasus permission to take or have taken still and moving photographs and films including television pictures of our/ my son, daughter, ward .By signing this the Rider, Parent or Guardian, consents and authorizes Pegasus, its advertising agencies, news media, and other persons interested in Pegasus and its work, to use and reproduce the photographs, films and pictures and to circulate and publicize the same by all means including without limiting the generality of the foregoing newspapers, television media, brochures, films, pamphlets, instructional material, books, and clinical material. With respect to the foregoing matters, no inducements or promises have been made to us / me to secure our / my signature (s) to this release other than the intention of Pegasus to use or cause to be used, such photographs, films and pictures for the primary purpose of promotion and aiding Pegasus and its work.

**YES, PHOTOS AUTHORIZED:** **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**NO PHOTOS, YOU MUST CIRCLE "NO PHOTO'S" AND SIGN:** **Signature:** \_\_\_\_\_

**NOTE: IF YOU DO NOT CIRCLE "NO PHOTOS AND SIGN, PICTURES MAY BE TAKEN!**



## QUALIFICATIONS / RIDERS DRESS CODE

Dear Clients/Riders, Parents, Caregivers and Teachers,

**QUALIFICATIONS: Please keep this page for your information.**

- ❖ **Adults:** Riders must be certified as Special Needs by a Doctor or State.
- ❖ **Children:** Riders must be certified special Needs by Doctor, State / Public School system.
- ❖ All applicants must complete the “Client/Rider’s Packet” which MUST include a doctor’s signed approval for applicant to participate in the program.
- ❖ We accept riders 4 years of age and adults of all ages.
- ❖ Weight maximum: 180lbs. NO EXPECPTIONS, for SAFTY of the rider, horse, and volunteer.

### RIDER’S DRESS CODE:

For a safe and beneficial ride, we ask that everyone follow the dress code below. If the dress code is not followed the rider may be asked not to ride that week. Again, these rules are for the safety of the rider.

- ❖ Long pants: to protect rider’s legs from chaffing and getting pinched in the saddle and straps.
- ❖ Closed toe shoes, sneakers and boots are good, **NO SANDALS or FLIP FLOPS. If a rider is wearing any open-toe shoes, sandals, or flip flops they WILL NOT BE ALLOWED TO RIDE.**
- ❖ Dresses or skirts are not preferred for child’s comfort and safety.
- ❖ T-shirts, blouses and sweaters/jackets, anything comfortable, keep in mind weather conditions.
- ❖ HELMETS: Are provided by Pegasus and MUST be worn. Our Helmets comply with all state safetycodes. Riders can bring their own helmet if it complies with state safety code.

Please call (760) 772.3057, if you have any questions and leave a message, your call will be returned.

Thank you,

**Pegasus Therapeutic Riding Center**

**PARENTS / RIDERS COPY**

