

# A New Dawn Therapeutic Riding Program

1164 Blattdahl Road \* Mohrsville, PA 19541 \* 610-655-5271

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## RELEASES & PERMISSIONS

NO STUDENT CAN BE ACCEPTED FOR HIPPO THERAPY OR THERAPEUTIC RIDING INSTRUCTION UNTIL THIS FORM HAS BEEN COMPLETED BY THE PARENT/GUARDIAN. If the student is of legal age (18 yrs old), he/she may complete the form, if he/she is legally competent to do so. Hippotherapy and/or Therapeutic Riding will be under strict supervision and, although every effort will be made to avoid any accident, NO LIABILITY can be accepted by any of the organizations concerned, including A New Dawn Therapeutic Riding Program.

Yes, I would like \_\_\_\_\_ to participate in Hippotherapy or Therapeutic Riding. I have discussed participation in this program with the client's physician. I am aware there are risks involved in Hippotherapy or Therapeutic Riding. I understand that there is always the possibility of an accident, or even death, when participating in this type of program and I hereby, intending to be legally bound, for myself, my heirs, executors or administrators, wave and release all claims for damages that I may have against A New Dawn Therapeutic Riding Program, it's Board of Directors, Instructors, Therapists, Aides, Volunteers and/or employees for any and all injuries and losses. I understand that NO LIABILITY can be accepted by any organizations concerned with this instruction, including A New Dawn Therapeutic Riding Program in the event of any accidents which may occur.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
*Client/Parent/Guardian*

Witness: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Cannot be A New Dawn employee)*

### Important! Please Note!

Should the physical condition of the student change at any time, a new physician's prescription must be provided. A new script is required to resume Hippotherapy/Therapeus. Please notify us immediately of any surgery, changes in treatment or medication.

I agree to immediately notify A New Dawn Therapeutic Riding Program about changes in the physical condition of the student, surgery, changed in treatment or medication.

Signed: \_\_\_\_\_  
*Client/Parent/Guardian*

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## Program Goals & Reviews

The staff at A New Dawn Therapeutic Riding Program is dedicated to delivering quality, effective Hippotherapy and Therapeutic (educational) riding instruction to every client. Student goals and activities are tailored to meet each individual student's physical, educational and emotional needs. Goals and lesson notes are reviewed at least annually to assess progress and establish new goals. These evaluations are conducted by the therapeutic riding instructor and or/occupational or physical therapist to ensure effective program design for each student. Therapeutic riding instructors may request a consultation with a physical/occupational therapist to assist in establishing and reviewing student goals and progress. To further facilitate a well-rounded education and therapy program, students (parents/guardians) are encouraged to provide A New Dawn staff with program goals, reports and information developed at home, by schools, or other service agencies working with the client.

## Authorization to Release Information

I hereby authorize A New Dawn Therapeutic Riding Program to release physical therapy evaluations and progress notes to any of the following sources: (Please initial your consent)

\_\_\_\_\_ Medical personnel following the client's progress

\_\_\_\_\_ School currently attended by client

\_\_\_\_\_ Community agencies providing services to the client

\_\_\_\_\_ Insurance companies processing claims for services rendered by A New Dawn Therapeutic Riding Program

I understand this authorization is in effect unless the client or guardian notifies A New Dawn in writing to the contrary:

A New Dawn MAY NOT release information to: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
*Client/Parent/Guardian*

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

## Photo Release

I DO DO NOT consent to and authorize the use and reproduction by A New Dawn Therapeutic Riding Program of any and all photos/audiovisual materials take of me for promotional material, educational activities and exhibit displays.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
*Client/Parent/Guardian*