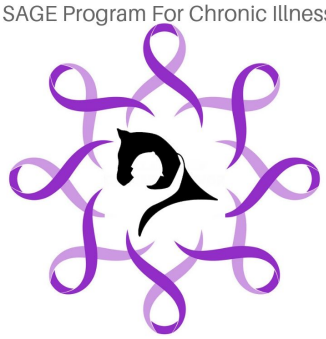
SAGE Program For Chronic Illness



High Horses Therapeutic Riding Program

Name: _____ Daytime Phone: _____

Email Address: _____

Mailing Address: _____

Age: _____ Gender: □ Female □ Male

Have you had any horseback riding experience? Yes ___ None ___ Limited ___

Brief synopsis of riding experience:

_____

_____

_____

Do you currently exercise (type, frequency and amount):

_____

_____

Do you have any physical limitations:

_____

_____

Why are you taking this class:

_____

_____

Please mark all that apply to you:

□ Anxiety/Panic Disorder
□ Balance Issues
□ High Blood Pressure
□ Joint Problems
□ Peripheral Neuropathy
□ Recent Surgery (in past year)
□ Recent Injuries
□ Spells of Dizziness or Fainting
□ Spinal Disease

PHOTO RELEASE:

□ I DO

□ I DO NOT

_____consent to and authorize the use and reproduction by High Horses Therapeutic Riding 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.

Please give a *brief* synopsis of your health:

_____

_____

_____

_____

_____

_____

_____

_____

I take full responsibility for my voluntary participation in the exercise class offered by High Horses Therapeutic Riding Program. I agree to be gentle and work at my own capacity in the class and when practicing at home. I release the instructor and High Horses TRP from liability resulting from any injury or discomfort from my attendance and participation.

Signature _____ Date _____