Liebe Cornelia Hooves 2 Healing Foundation
5938 Hovan Ave. Plant City, FL, 33565
www.lch2h.org

LCH2H Rider Participation Paperwork

Participant Registration Information- Please write clearly in ink.

Legal Name: ______________________ Date of Birth: ____________

Address: ______________________ City, State, Zip Code ____________

Primary Phone Number: ____________ Secondary Phone Number: ____________

Email Address: ______________________

School or Institution currently attending:

Parent or Legal Guardian Information (if applicable)

Parent / Guardian Name: ______________________

Primary Phone Number: ____________ Secondary Phone Number: ____________

Address: ______________________

Caregiver Name: ______________________

Primary Phone Number: ____________ Secondary Phone Number: ____________

Address:

Photo Release

I attest that I have read and understand the Photo Waiver Policy attached.

Parent / Legal Guardian Signature Date

Rider Authorization for Emergency Medical Treatment

In emergency situations when medical aid/ treatment is required, due to illness or injury, during the process of receiving services or while being on the property of LCH2H, I authorize the following:

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

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I give consent for medical treatment/ aid to include (but not limited to) x-ray, surgery, hospitalization, medication and any treatment procedure deemed “lifesaving” by a licensed physician. This provision will only be invoked if the person below is unable to be reached.

Emergency Contact: ______________________ Phone Number: __________

Emergency Contact: ______________________ Phone Number: __________

Physician’s Name: ______________________ Phone Number: __________

Preferred Medical Facility: ______________________________

Health Insurance Company: ____________________ Policy Number: __________

Parent / Legal Guardian Signature Date

UNCONDITIONAL GENERAL RELEASE

WARNING-UNDER FLORIDA LAW, AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO, OR THE DEATH OF, A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES.

I ________________________, a participant, client, volunteer, or student of the legal guardian of a participant, client, volunteer, or student (“Participant”) in a program, or activity taking place under the sponsorship of or at the facilities of **Liebe Cornelia Hooves to Healing (LCH2H).** a Florida not for profit corporation, hereby give consent and approval to the participant in any and all programs, events, or activities taking place under the sponsorship of or at all the facilities of LCH2H (“Activities”). I fully understand that my decision to be a Participant, or to allow such person named above to be a Participant, poses risks of personal injury, property damage, death and/or other loss that may arise while participation in the Activities. I assume all risks and hazards related to the outcome of the Activities as well as transportation to and from all Activities. In consideration of Participants’ being allowed to participate in the Activities, on behalf of the Participant, Participant’s heirs, personal or legal representatives, successors and assigns, I hereby irrevocably and unconditionally release and forever discharge LCH2H and its affiliates from any and all claims, demands, causes of actions, suits, or liability of any kind with LCH2H, directors, officers, employees, agents, independent contractors, representatives attorneys, volunteers successors and assigns, and all persons acting by, through, under or in concert with any of them (collectively “the Releases’”), from any and all claims or causes of action whatsoever, in law or in equity, whether known or unknown at this time, based on action, cause or thing occurring on, prior to, or following the date hereof, and, in particular, without limiting the generality of the foregoing, all claims arising out of or relating to the activities, even if such liability or damage results from the sole negligence of the Releases’.

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I hereby authorize the Releases to act in their discretion on behalf of participant in providing, requesting, or authorizing the provision of emergency medical services ("Emergency Services"). I acknowledge full responsibility for any charges associated with the rendering of any and all Emergency Services and I indemnify the Releases from any and all claims, expenses, or other charges related to their decision to provide or to not provide Emergency Services. I understand and agree that this document shall be constructed according to the laws of the State of Florida, and that this Unconditional General Release shall be as broad and inclusive as is permitted by the laws of the State of Florida, If any portion of this document is held to be invalid of no force of effect, I agree that the balance shall continue in full force and effect.

This Unconditional General release shall be immediately effective upon its execution.

I HAVE READ AND UNDERSTAND THIS DOCUMENT DATED this ______ day of ____________, 2025.

Signature of Participant / Parent or Legal Guardian ________________________________

Printed Name of Participant, Parent or Legal Guardian

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Liebe Cornelia Hooves to Healing – Rider Questionnaire

The following questionnaire is designed to give LCH2H. Information pertaining to each individual rider's behavior and ability. This will help us prepare group lesson plans and assist you in attaining individual goals. Please complete this questionnaire in as much detail as possible using the back of the page or attaching an additional sheet if necessary.

Name:____ Age:______________

1. Briefly describe disability:____

   ____

   ____

2. What are the physical symptoms of the disability?_________________________________

   ____

   ____

3. What goals do you hope to achieve by participating in this program?_____________________

   ____

   ____

4. What other treatments or therapies have the participant undergone? Please specify when and for

   how long:____

   ____

   ____

5. How would you describe their concentration, attention span and general awareness?____________

____

____

6. Would you characterize them as happy, aggressive easygoing, enthusiastic, passive, excitable, depressed, introverted or extroverted?____

____

____

7. How do they communicate? (Expressive and Receptive Language)___________________________

____

____

8. Is there a history of incontinence?____

____

____

9. What positive reinforcements do they respond to?___________________________________

____

____

10. Please indicate any other areas of the potential rider's behavior and personality that will help us to best communicate, understand and work with the rider.________________________________

____

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Completed by:_______________________________ Date:_______________

Relationship with Rider:_______________________________________

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Liebe Cornelia Hooves to Healing
Rider Goal Sheet

Please assist us in helping you get the most out of your classes at Liebe Cornelia Hooves to Healing by filling out the following goal sheet. Please speak with Instructor if you need help filling this out. We will evaluate and possibly reassess goals after each riding session.

Name: ______________________

Parent / Guardian / Caregiver: ______________________

Email: ______________________

Class day and times: ______________________

All goals are reflective of the current session. The categories are meant as a guide and may not apply to all students.

Rider Goals: ______________________

Physical Goals: ______________________

Cognitive Goals: ______________________

Social Goals: ______________________

Long Term Goals (over the next year): ______________________

Parent / Guardian / Caregiver Signature: ______________________ Date: __________

Instructor Review and Signature: ______________________ Date: __________

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PARTICIPANT CONSENT FOR RELEASE FOR INFORMATION

I hereby authorize Liebe Cornelia Hooves to Healing (LCH2H) and CTRI's to release information from the records of: ____DOB_______________________

The information is to be released to LCH2H for the purpose of developing an equine activity program for the above-named participant. The information to be released is indicated below:

Medical history

Physical therapy evaluation, assessment and program plan

Speech therapy evaluation, assessment and program plan

Mental health diagnosis and treatment plan

Individual Habilitation Plan (IHP)

Classroom Individual Education Plan (IEP)

Psychological evaluation, assessment and program plan

Cognitive-behavioral management plan

Other: ____

This release is valid for one year and can be revoked, in writing, at my request.

Signature; ___________________________________ Date: _________________________________

Print Name: ____

Relation to Participant: ___________________________________

Please send materials to: Leibe Cornelia Hooves to Healing

Attn: Program Director

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PARTICIPANT STATISTICAL INFORMATION FORM
FOR STATISTICAL USE ONLY

Completion of this form will assist LCH2H in tracking information needed to apply for grant funding for programs. This information received from this form will remain confidential. This information will not affect the decision for a participation to ride with Leibe Cornelia Hooves to Healing.

Participant Name: ______________________________ DOB: ___________ Gender: __________

Mailing Address: ____

Disability: ____

Ethnicity (circle what applies):

American Indian/Alaskan Hispanic

Asian/Pacific Islander White (non-Hispanic)

Black Other

I choose not to disclose

Annual Household Income:

$0 - $10,000 $11,000- $20,000 $21,000 - $30,000

$31,000 - $50,000 $51,000 - $75,000 $75,000 – plus

Number of employed family members: __________

Number of total family members: ______________

Adult Signature: ____Date: ____________

How did you hear about this program: ____

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Photo Waiver Policy

For good and valuable consideration, the receipt of which is hereby acknowledged, I ______________________ (guardian's name), hereby grant Liebe Cornelia Hooves 2 Healing, LLC (LCH2H) permission to use _____________________'s (minor's name) likeness in photographs in any and all of its publications, including but not limited to LCH2H's printed and digital publications. I understand and agree that any photographs using _____________________'s (minor's name) likeness will become property of LCH2H and will not be returned.

I acknowledge that since my participation with LCH2H is voluntary, I will receive no financial compensation.

I hereby irrevocably authorize LCH2H to edit, alter, copy, exhibit, copy, publish, or distribute this photograph for purposes of publicizing LCH2H's programs or for any other related, lawful purposes. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein _____________________'s (minor's name) likeness appears. Additionally, I waive any right to royalties or other compensation arising out of, or related to, the use of the photograph.

I hereby hold harmless and release and forever discharge LCH2H from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators, or any other person acting on my behalf or behalf of my estate have or may have by reason of this authorization.

Signed by _____________________ (guardian's name), the authorized parent or guardian of

_____________________ (minor's name) of ____ (address) with the intent of being legally bound on ________________ (date).

____
Printed Name

__________________________________ ________________________

Signature Date

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Riders Medical History and Physician's Release
Must be completed by Physician

Name: ____________________ DOB: __________ Height: __________ Weight: __________

Primary Diagnosis: ____________________ Date of Onset: __________

Secondary Diagnosis: ____________________ Date of Onset: __________

Tertiary Diagnosis: Date of Onset:

Shunt Present: Yes ___ No ___	Date of Last Revision:		Tetanus shot: Yes ___ No ___	Date:

Seizure Type:		Controlled: Yes ___ No ___	Date of last Seizure:	

PLEASE LIST ALL CURRENT MEDICATIONS:

____________________ Taken for: ____________________

____________________ Taken for: ____________________

____________________ Taken for: ____________________

____________________ Taken for: ____________________

____________________ Taken for: ____________________

Any contagious diseases:

Please indicate if a patient has a problem and/or surgeries in any of the following areas. If yes, please comment, using the back of the form if necessary.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disabilities			

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Mental Impairment			
Psychological			
Impairment			
Incontinence			
Coordination			
Balance			
Mobility: independent Ambulation: Yes ___ No ___		Crutches: Yes ___ No ___	
Wheelchair: Yes ___ No___		Braces: Yes ___ No ___	
Past/ Prospective Surgeries:			
Special Precautions/Needs:			

The following conditions, if present, may represent precautions and contraindications to therapeutic horse riding. Please be sure to clearly identify and check the boxes if any of the following conditions are present and explain to what degree			
Orthopedic		**Medical/Surgical**	
Spinal Fusion		Allergies	
Spinal Instabilities/ Abnormalities		Cancer	
Internal Spinal Stabilization Devices		Poor Endurance	
Atlantoaxial Instabilities		Recent Surgery	
Scoliosis		Diabetes	
Kyphosis		Peripheral Vascular Disease	
Lordosis		Varicose Veins	
Hip Subluxation and Dislocation		Hemophilia	
Osteoporosis		Hypertension	
Pathologic Fractures		Serious Heart Condition	
Coxas Arthrosis		Stroke (Cerebrovascular Accident)	
Heterotopic Ossification			
Osteogenesis imperfecta		**Neurologic**	
Cranial Deficits		Seizure disorders	
Spinal Orthoses		Hydrocephalus/shunt	
Secondary Concerns		Spina Bifida	
Behavior Problems		Tethered Cord	
Age two – four years		Chiari ll Malformation	
Acute exacerbation of chronic disorder		Hydromyelia	
Indwelling catheter		Paralysis due to Spinal Cord Injury	
Integumentary/ Skin			

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Riders with Down Syndrome- PLEASE NOTE

Due to the nature of the activity of horseback riding, no individual diagnosed with Down Syndrome can be accepted for riding instruction without proof of a negative diagnostic x-ray for Atlantoaxial Instability. Please provide the following information:

a) Most recent cervical x-ray for AAI: [ ] Positive [ ] Negative…Date of X-Ray_____________________
b) Annual cervical exam for AAI: [ ] Positive [ ] Negative…Date of Exam__________________________

Physician Verification -- Please PRINT your name, sign & date – THANK YOU

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications.

THIS MUST BE FILLED OUT AND SIGNED BY PHYSICIAN TO ENTER THE EQUINE THERAPY PROGRAM.

Physician Name/Title: (please print): ____________________

Signature: ____________________ Date: ____________________

Address: ____________________ Phone: ____________________

Additional Comments: