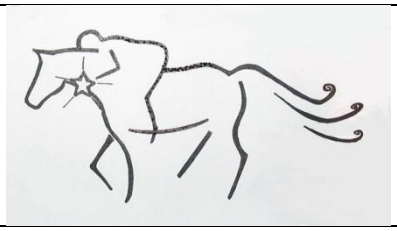


If Wishes Were Horses, Inc
A therapeutic riding program at
Fleet Equestrian Center, LLC
2142 Hicklin Bridge Rd Edgemoor, SC 29712

For Teacher or Group Leader CLASS/GROUP REGISTRATION FORM

Number or Riders in your group _____

Number of Volunteers coming with your group _____

Number of Ambulatory Riders _____

Important information about your group_____
_____
_____

What you would like for your class/group to work on while they are riding horses.
_____
_____
_____
_____

Will you be providing lesson plans to be put to use on horseback? Yes No

* lesson plans can be as simple as rider makes eye contact or makes an utterance or gesture when asking horse to walk on.

*lesson plans can be something that you are currently working on in class, that you want to work on while riding, such as colors, numbers, shapes, choices etc.

**Please have filled out all individual forms for your students.

If Wishes Were Horses, Inc
A non-profit 501 (c) (3), therapeutic riding program
Fleet Equestrian Center, LLC
2142 Hicklin Bridge Rd Edgemoor, SC 29712

Information for Physician and Prescrition to ride page 1 of 2

Client Name_____ DOB_____

Parent/Guardian _____ Phone_____

The following conditions, if present, may represent precautions or contradictions to therapeutic riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree (Circle and comment if needed).

Orthopedic	**Medical/ Surgical**	**Secondary Concerns**
Spinal Fusion	Cancer	Behavioral Problems
Spinal Instabilities / Abnormalities	Poor Endurance	Age under Two years
Atlantoaxial Instabilities	Recent Surgery	Age Two-Four years
Scoliosis	Diabetes	Acute Exacerbation of -
Kyphosis	Peripheral Vascular Disease	Chronic Disorder
Lordosis	Varicose Veins	Indwelling Catheter
Hip Subluxation and Dislocation	Hemophilia	
Osteoporosis	Serious Heart Condition	**Neurological**
Pathologic Fractures	Stroke/CVA	Hydrocephalus/shunt
Coaxes Arthrosis		Spina Bifida
Heterotopic Ossification		Tethered Cord
Osteogenesis Imperfecta		Chiari II Malformation
Spinal Orthoses		Hydromyelia Paralysis
Cranial Deficits		Due to Spinal Cord Injury
Internal Spinal Stabilization Devices		Seizure Disorders
Areas of Concern	**Areas of Concern**	**Mobility Level**
Auditory	Orthopedic	Independent Ambulation
Visual	Allergies	Crutches
Speech	Learning Disabilities	Braces
Cardiac	Neurological	Wheelchair
Circulatory	Mental Impairment	Other
Pulmonary	Psychological	
Muscular	Other	

Comments_____
_____
_____
_____
_____
_____

If Wishes Were Horses, Inc
A non-profit 501 (c) (3), therapeutic riding program
Fleet Equestrian Center, LLC
2142 Hicklin Bridge Rd Edgemoor, SC 29712

Information for Physician and Prescription to Ride page 2 of 2

Client Name _____DOB _____Age _____

Diagnosis/Problem _____

Precautions for this diagnosis/problem_____

_____

Any Past Surgeries to date? ___ Yes ___No Future Surgeries? ___ Yes ___No

Type of surgery/Related precautions_____

_____

********** **For Persons with Down Syndrome only**********

Cervical X-ray for Atlantoaxial Instability Date of X-ray _____

___Positive ___Negative for signs of Atlantoaxial Instability.

**********For Persons with Seizures only**********

Height _____ Weight _____ Seizure Type _____ Controlled __Y __N Date of Last Seizure _____

Seizure Medications_____

****

Licensed Medical Professional Rx

I recommend horseback riding for _____ (client name) as an activity that could provide benefits to their health, wellness, and enjoyment of life. I find horseback riding to be safe activity in which the stated client can participate, while supervised.

To my knowledge there is no reason this person cannot participate in therapeutic horseback riding. However, I understand that the therapeutic riding center will weigh the medical information against the existing precautions and contradictions of PATH Intl standards.

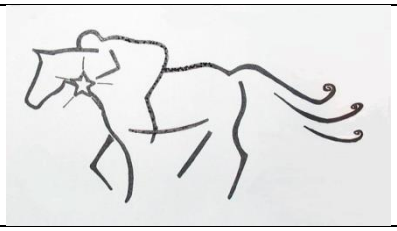
Medical Professional's Signature _____Title_____

Medical Professional's Name (print) _____

Office Phone_____ Office Name_____

Date _____ City_____ State _____

View our farm online at: www.fleetequestriancenter.com email at: fec2014@outlook.com
Inquiries can be made to Margaret Fleet, 803 517 4563.
Margaret Fleet - PATH Intl Certified Instructor



If Wishes Were Horses, Inc
A therapeutic riding program at
Fleet Equestrian Center, LLC
2142 Hicklin Bridge Rd Edgemoor, SC 29712

For Parent 1 of 2 Rider Authorization for Emergency Medical Treatment

In the event emergency medical aid/treatment is required during the process of receiving services, or while being on the property of the agency, I authorize If Wishes Were Horses to:

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

Date_____Signature_____

Rider's Name_____Phone_____Cell_____
Address_____(city,state,zip)_____
Emergency Contact_____Phone_____Cell____
Physician's Name_____Office Phone_____
Preferred Medical Facility _____
Health Insurance Co_____ Policy #_____

Consent Plan

__ I do give my consent for emergency medical 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 parent/guardian or emergency contact is unable to be reached. Below for Parent/Guardian

Date_____ Consent Signature _____
Print Name (Parent/Guardian)_____Phone_____
Cell_____ Work/Other_____
Address (if different from rider)_____

Non-Consent to Emergency Medical Treatment

__ I do NOT give consent for emergency medical treatment/aid in the case of illness or injury. In the event of an emergency I wish the following to take place:

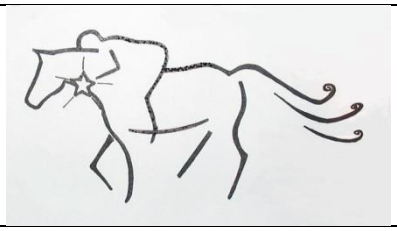
_____
_____

Date_____ Non-Consent Signature_____
Print Name (Parent/Guardian)_____Phone_____

Photo Release

__ I consent to and authorize
__ I do NOT consent to or authorize
the use and reproduction by If Wishes Were Horses, Inc of any and all photographs and any other audiovisual materials taken of me for promotional material, educational activities, exhibitions, or for any other use for the benefit of the program.

Date_____ Signature_____



If Wishes Were Horses, Inc

A therapeutic riding program at
Fleet Equestrian Center, LLC
2142 Hicklin Bridge Rd Edgemoor, SC 29712

For Parent 2 of 3 RIDER PERMISSION SLIP

Client's Name_____DOB_____

*Diagnosis*_____School/Group _____

Parents/Guardians Names_____

Address_____City_____

State_____Zip_____Email_____

Home Phone_____ Work/Other_____Cell(s)_____

Liability Release

_____(Rider's name) would like to participate in If Wishes Were Hores, Inc program. I acknowledge the inherent risks due to the nature of horseback riding. However, I feel that the possible benefits to 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 Margaret Fleet, Bryan Fleet, Fleet Equestrian Center, LLC, If Wishes Were Horses, INC., its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or employees for any and all injuries and/or losses my son/daughter/ward may sustain while participating in If Wishes Were Horses, Inc.

_____I DO give permission for my child to ride

_____I do NOT give permission for my child to ride but I DO give them permission to visit the farm.

To be eligible, riders at If Wisher Were Horses, Inc.:

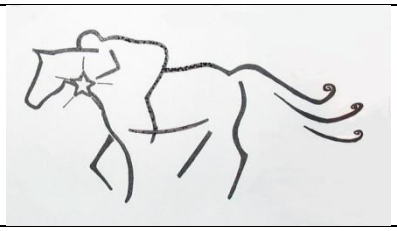
1. Must be at least three years of age. Must not be over the age of 22.
3. May not have a history of having uncontrolled Grand Mal seizures.
4. For Down Syndrome riders: Must have a recent Negative Atlantoaxial instability X-ray and verification from a Medical Doctor (within the past twelve months) or a 1 time visit waiver form.
5. Must not have a weight of over 200 lbs.

Eligibility Verification – I certify that my child/ward meets the eligibility requirements as outlined above.

*** We reserve the right to refuse any rider.**

"UNDER SOUTH CAROLIN LAW, AN EQUINE ACTIVITY SPONSOR OR EQUINE PROFESSIONAL IS NOT LIABLE FOR THE INJURY TO OR THE DEATH OF A PARTICIPANT IN AN EQUINE ACTIVITY RESULTING FROM THE INHERENT RISK OF EQUINE ACTIVITY, PURSUANT TO ARTICLE 7, CHAPTER 9 OF TITLE 47, CODE OF LAWS OF SOUTH CAROLINA."

Date_____ Signature of Parent/Guardian_____



If Wishes Were Horses, Inc
A therapeutic riding program at
Fleet Equestrian Center, LLC
2142 Hicklin Bridge Rd Edgemoor, SC 29712

For Parents 3 of 3 CHECK LIST FOR RIDER INFORMATION PACKET

I have returned my child's/ward's permission slip ___Yes ___No
(to travel to location)

I have returned my child's/ward's emergency ___Yes ___No
medical treatment form

I have returned the Information for Physician forms ___Yes ___No

I give permission for my child/ward to ride ___Yes ___No
(Information for physician must be completed)

I do not give permission for my child/ward to ride ___Yes ___No

Signature _____ Date_____

*******All forms must be completed for student to ride.*******

If you do not want your child/ward to ride, return the checklist along with the permission slip and the emergency medical treatment form.

If Wishes Were Horses, Inc

A non-profit 501 (c) (3), therapeutic riding program
Fleet Equestrian Center, LLC
2142 Hicklin Bridge Rd Edgemoor, SC 29712

For Children with Trisomy 21 or Down's Syndrome

In order to participate in horseback riding, a Negative Annual Cervical X-ray for Atlantoaxial Instability within the last 12 months is required. Parents may waive this X-ray for 1 time visits to the farm by signing and agreeing to the hold harmless statements below and in additional farm paperwork. This does NOT take the place of required Medical Paperwork that must be signed by a Licensed Medical Professional in order to ride.

Participant's Name _____DOB_____

Parent's/Guardian's Name_____

The Parent/Guardian must Read, Understand and Initial all items prior to the Participant participating in Equine Activities.

___1. I am the Parent and/or Legal Guardian of the Participant named above and I am executing this form on behalf of the Participant in my capacity as parent and/or guardian and with the intent that this form be binding on myself and to my Child the Participant for all legal purposes.

___2. I Understand there are Inherent RISKS associated with Equine Activities and that injuries resulting from these RISKS can occur.

___3. I am choosing to **waive** the requirement of the Negative Annual Cervical X-ray for Atlantoaxial Instability within the last 12 months for the one time visit to Fleet Equestrian Center, LLC on the date(s) of _____

___4. I Freely Accept and Fully Assume All Responsibility for the Inherent RISKS and the possibility of personal injury, death, property damage or loss which might result from my child/ward being a Participant. In addition to consideration given for my child to Participate in Equine Activity, I and my heirs, executors, administrators and assigns agree to hold harmless and to waive all claims against **Margaret Fleet, Bryan Fleet, Fleet Equestrian Center, LLC, If Wishes Were Horses, Inc., its directors, board members, participants, employees, volunteers, and any other person associated with activates carried out on the property, for all time.** I further state I am aware that signing this form, waives certain legal rights I and/or my child Participant and/or our "Legal Representatives" might have against the **hosting entities** named above.

___5. I fully attest that my child, the Participant, has none of the below mentioned symptoms, to this date and that I understand what Atlanto Axial instability is and that I fully understand that Atlanto Axial Instability is a contradiction to horseback riding for medical, safety, and legal reasons.

Atlanto Axial instability is caused by an increased flexibility in the muscles and ligaments between the first and second vertebrae in the neck. This can lead to these ligaments and muscles becoming loose and the joint becomes unstable. In some cases bones in the neck can also be underdeveloped and can be the cause of instability. It is currently recommended by the Medical Guidelines for children and adolescents with Down syndrome that signs and symptoms of instability should be addressed immediately by a medical professional.

These include: □Abnormal head posture □Altered gait/ unstable on their feet
□A stiff neck that is not getting any better □Deterioration in bladder or bowel control
□Neck pain and pain behind the ear □Deteriorating manipulative skills □Restricted neck movement

___6. Any injuries as a result of horseback riding are my full responsibly as the legal Parent/Guardian. I have been made aware of presenting signs and symptoms of Atlanto Axial Instability. I know that this list is **not** all inclusive.

I wish for my child to participate despite any warnings and risks.

_____ _____

Parent/Guardian Signature Date

If Wishes Were Horses, Inc

A non-profit 501 (c) (3), therapeutic riding program
Fleet Equestrian Center, LLC
2142 Hicklin Bridge Rd Edgemoor, SC 29712

Helmet Waiver

In order to participate in horseback riding, all children are required to wear safety helmets. This is a waiver for a 1 time visit to the farm accomplished by signing and agreeing to the hold harmless statements below and in additional farm paperwork. This does NOT take the place of required Medical Paperwork that must be signed by a Licensed Medical Professional in order to ride.

Participant's Name _____DOB_____

Parent's/Guardian's Name_____

The Parent/Guardian must Read, Understand and Initial all items prior to the Participant participating in Equine Activities.

___1. I am the Parent and/or Legal Guardian of the Participant named above and I am executing this form on behalf of the Participant in my capacity as parent and/or guardian and with the intent that this form be binding on myself and to my Child the Participant for all legal purposes.

___2. I Understand there are Inherent RISKS associated with Equine Activities and that injuries resulting from these RISKS can occur.

___3. I am choosing to **waive** the requirement of wearing a safety helmet for the one time visit to Fleet Equestrian Center, LLC on the date(s) of _____

___4. I Freely Accept and Fully Assume All Responsibility for the Inherent RISKS and the possibility of personal injury, death, property damage or loss which might result from my child/ward being a Participant. In addition to consideration given for my child to Participate in Equine Activity, I and my heirs, executors, administrators and assigns agree to hold harmless and to waive all claims against **Margaret Fleet, Bryan Fleet, Fleet Equestrian Center, LLC, If Wishes Were Horses, Inc., its directors, board members, participants, employees, volunteers, and any other person associated with activates carried out on the property, for all time.** I further state I am aware that signing this form, waives certain legal rights I and/or my child Participant and/or our "Legal Representatives" might have against the **hosting entities** named above.

__5. I fully understand that this is a very serious safety issue that should not be taken lightly due to the inherent risk and nature of this activity. I find more benefit in my child riding than in the required safety precaution of wearing a riding helmet.

If it is found that my child cannot tolerate wearing a safety helmet and that she/he is at more risk of self-harm by being forced to wear a helmet or that she/he cannot ride/participate due to emotional distress/disturbance due to wearing a helmet, I hereby give permission for my child to ride without a helmet while they are mounted.

_____ _____

Parent/Guardian Signature Date

If Wishes Were Horses, Inc

A non-profit 501 (c) (3), therapeutic riding program
Fleet Equestrian Center, LLC
2142 Hicklin Bridge Rd Edgemoor, SC 29712

History of Grand Mal Seizure Waiver

In order to participate in horseback riding, all children may not have a history of uncontrolled Grand Mal Seizures. This is a waiver for a 1 time visit to the farm accomplished by signing and agreeing to the hold harmless statements below and in additional farm paperwork. This does NOT take the place of required Medical Paperwork that must be signed by a Licensed Medical Professional in order to ride.

Participant's Name _____DOB_____

Parent's/Guardian's Name_____

The Parent/Guardian must Read, Understand and Initial all items prior to the Participant participating in Equine Activities.

___1. I am the Parent and/or Legal Guardian of the Participant named above and I am executing this form on behalf of the Participant in my capacity as parent and/or guardian and with the intent that this form be binding on myself and to my Child the Participant for all legal purposes.

___2. I Understand there are Inherent RISKS associated with Equine Activities and that injuries resulting from these RISKS can occur.

___3. I am choosing to **waive** the requirement of NO History of Uncontrolled Grand Mal Seizures for the one time visit to Fleet Equestrian Center, LLC on the date(s) of _____

___4. I Freely Accept and Fully Assume All Responsibility for the Inherent RISKS and the possibility of personal injury, death, property damage or loss which might result from my child/ward being a Participant. In addition to consideration given for my child to Participate in Equine Activity, I and my heirs, executors, administrators and assigns agree to hold harmless and to waive all claims against **Margaret Fleet, Bryan Fleet, Fleet Equestrian Center, LLC, If Wishes Were Horses, Inc., its directors, board members, participants, employees, volunteers, and any other person associated with activates carried out on the property, for all time.** I further state I am aware that signing this form, waives certain legal rights I and/or my child Participant and/or our "Legal Representatives" might have against the **hosting entities** named above.

__5. I fully understand that this is a very serious safety issue that should not be taken lightly due to the inherent risk and nature of this activity. I find more benefit in my child riding than in the required safety precaution of not riding due to my child's history of Uncontrolled Grand Mal Seizures.

My child is currently not experiencing Uncontrolled Grand Mal Seizures.
They are on the following seizure medication(s) for a time of ____Years ____ Months

_____

I understand that the farm may still not let my child ride if they have a seizure or are above a certain weight or size. Weight _____ Height _____

_____ _____

Parent/Guardian Signature Date