Sebastian Riding Associates, Inc.
Therapeutic & Educational Riding Programs for Children & Adults with Disabilities
3589 B Water Street ♦ Collegeville, PA 19426 ♦610-489-3741 ♦ www.sebastianriding.org

RELEASES & PERMISSIONS

NO STUDENT CAN BE ACCEPTED FOR HIPPOTHERAPY/RIDING INSTRUCTION UNTIL THIS FORM HAS BEEN COMPLETED BY THE PARENT/GUARDIAN. If the student is of legal age (18), he/she may complete the form, if he/she is legally competent to do so. Hippotherapy and/or riding instruction will be under strict supervision and, although every effort will be made to avoid any accident, NO LIABILTY can be accepted by any of the organizations concerned, including Sebastian Riding Associates.

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, waive and release all claims for damages I may have against Sebastian Riding Associates, its Board of Directors, instructors, therapists, aids, volunteers and/or employees, Evansburg State Park, DCNR and the Commonwealth of Pennsylvania, for any and all injuries and losses. I understand that NO LIABILITY can be accepted by any organizations concerned with this instruction, including Sebastian Riding Associates in the event of any accident which may occur.

✓ Signed: ____________________________________ Date: ______________________________
Client/Parent/Guardian

Witness: ____________________________________ Date: ______________________________
(Cannot be a Sebastian Staff Member)

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/riding following surgery. Please notify us immediately of any surgery, changes in treatment or medication.

I agree to immediately notify Sebastian Riding Associates about changes in the physical condition of the student, surgery, changes in treatment or medication.

✓ Signed: ____
Client/Parent/Guardian

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Program Goals & Reviews

The staff at Sebastian Riding Associates is dedicated to delivering effective hippotherapy and therapeutic and educational riding instruction to every student at Sebastian. 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 Sebastian 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 Sebastian Riding Associates to release physical therapy evaluations and progress notes to any of the following sources:
Please place consenting initials.

_____ Medical personnel following the client's progress

_____ School currently attended by the client

_____ Community agencies providing services to the client

_____ Insurance companies processing claims for services rendered by Sebastian Riding Associates

I understand that this authorization is in effect unless the client or guardian notifies Sebastian in writing to the contrary:

Sebastian 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 Sebastian Riding Associates of any and all photos/audiovisual materials taken of me for promotional material, educational activities and exhibit displays.

✓ Signed: ___________________________________ Date: ______________________________
Client/Parent/Guardian