



Cincinnati Therapeutic Riding and Horsemanship  
1342 U.S. Highway 50, Milford OH 45150  
Phone: 513-831-7050/Secure Fax: 844-716-2708  
[www.ctrhohio.org](http://www.ctrhohio.org)

### Rider Information and Consent Form 2024

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_ How did you hear about CTRH? \_\_\_\_\_  
In the event, emergency medical aid/treatment is required, due to illness or injury, during the process of receiving services or while being on the property of the agency, I authorize Cincinnati Therapeutic Riding and Horsemanship to:  
1. Secure and retain medical treatment and transportation, if needed.  
2. Release records upon request to the authorized individual or agency involved in the medical emergency treatment.

**In case of emergency, please print two names to contact:**

\_\_\_\_\_  
Name Relationship Phone

\_\_\_\_\_  
Name Relationship Phone

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Is there a Third Party Payer (CCDD, etc.)? \_\_\_\_\_

Do you receive Medicaid? \_\_\_\_\_ If yes, what type? \_\_\_\_\_

**Consent Plan:** 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 person below is unable to be reached.

**Consent Signature:** \_\_\_\_\_ Date: \_\_\_\_\_  
Rider/Parent/Guardian/Caregiver

Print Name \_\_\_\_\_ Phone: \_\_\_\_\_

**Non Consent Plan:** I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

\_\_\_\_\_  
\_\_\_\_\_

**Non Consent Signature:** \_\_\_\_\_ Date: \_\_\_\_\_  
Rider/Parent/Guardian/Caregiver OVER →

Does applicant have any fears we should know? (i.e., falling, fear of heights, animals, etc.)

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Does applicant have any history of animal abuse? (if yes, please explain)

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List any medical conditions which might be relevant in an emergency. (i.e., bee sting, allergy, heart condition, etc.)

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Please list any additional information that would be helpful for our instructors and volunteers? If you are a returning rider please list any changes the CTRH staff need to be aware of. (i.e., change of medications, surgeries, etc.)

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**Release of Liability**

I, \_\_\_\_\_, a rider, parent or legal guardian of a rider, would like to participate in the Cincinnati Therapeutic Riding and Horsemanship Program. I acknowledge that risks are inherent in horseback riding and equine activity. However, I feel that the possible benefits to myself/son/daughter/ward are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors and administrators, waive, release and exonerate Cincinnati Therapeutic Riding and Horsemanship, its Trustees, Board of Directors, officers, instructors, therapists, aides, volunteers, independent contractors and/or employees from any and all tort and civil liability, damages and claims arising from or related to all activities associated with Cincinnati Therapeutic Riding and Horsemanship, including but not limited to any injuries and/or losses I/my son/ daughter/ward may sustain while participating in Cincinnati Therapeutic Riding and Horsemanship. I understand that some of the inherent risks in equine activity include, but are not limited to:

- A. The propensity of an equine to behave in ways that may result in injury, death, or loss to persons on or around the equine;
- B. The unpredictability of an equine's reaction to sounds, sudden movement, unfamiliar objects, persons, or other animals;
- C. Hazards, including, but not limited to, surface and subsurface conditions;
- D. A collision with another equine, another animal, a person, or an object;
- E. The potential of an equine activity participant to act in a negligent manner that may contribute to injury, death, or loss to the person of the participant or to other persons, including, but not limited to, failing to maintain control over an equine or failing to act within the ability of the participant.

I agree that I have been given sufficient time to read, understand and ask questions, if any, concerning the nature and scope of the Voluntary Waiver and Release Agreement.

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Date

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Participant Signature

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Parent/Guardian/Caregiver (if participant is a minor)

**Photo Release:** I do \_\_\_\_\_ I do not \_\_\_\_\_ consent to and authorize the use and reproduction by Cincinnati Therapeutic Riding and Horsemanship of any and all photographs and any other visual materials taken of me/my son/ daughter/ward for promotional printed material, educational activities or for any other use for the benefit of the program.

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Date

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Signature of Rider/Parent/Guardian/Caregiver

Participant Demographic Information

Cincinnati Therapeutic Riding and Horsemanship is a nonprofit organization supported by philanthropic contributions. Many grant applications request anonymous demographic information be included. Your assistance is greatly needed to help maintain management programming fees. Every participant is asked to complete the following information, which will be kept confidential and used only for the purpose of securing philanthropic support.

Participant fees cover a small percentage of the total costs of programming and services. These fees are offset by philanthropic contributions from individuals, corporations, foundations/grants and other generous investors.

Participant Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_

Gender: \_\_\_ Male \_\_\_ Female

When did participant first start coming to CTRH? \_\_\_\_\_

County and State of Residence: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Ethnicity: \_\_\_ White/Caucasian \_\_\_ Hispanic Origin \_\_\_ Black/African American  
\_\_\_ American Indian \_\_\_ Asian/Pacific Islander \_\_\_ Other: \_\_\_\_\_

Household Income: *grantors often ask about anonymous income data to determine the amount of funding to award CTRH*

- \_\_\_ Less than \$25,519                      \_\_\_ \$62,360 - \$70,319
- \_\_\_ \$25,520 - \$34,479                    \_\_\_ \$70,320 - \$79,279
- \_\_\_ \$34,480 - \$43,439                    \_\_\_ \$79,280 - \$88-239
- \_\_\_ \$43,440 - \$52,399                    \_\_\_ \$80,240 - \$99,999
- \_\_\_ \$52,400 - \$61,359                    \_\_\_ \$100,000+                    \_\_\_ Prefer Not to Answer

Total Number in Household: \_\_\_\_ Total Number under age 19 in household: \_\_\_\_

Self / Parent / Guardian Occupation: \_\_\_\_\_

Self / Parent / Guardian Employer: \_\_\_\_\_

Does Employer offer Matching Gift Program? \_\_\_ Yes \_\_\_ No

Would you consider requesting a Matching Gift for CTRH in the future? \_\_\_ Yes \_\_\_ No

Does Employer provide grants and/or sponsorships in support of nonprofits? \_\_\_ Yes \_\_\_ No

Would you consider working with CTRH to request a grant or sponsorship from Employer? \_\_\_ Yes \_\_\_ No

If yes, please share your contact information: \_\_\_\_\_

Form Completed by: \_\_\_ Self \_\_\_ Parent/Guardian \_\_\_ Spouse \_\_\_ Aide

Form Completed on Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_