Hope on Horseback
Therapeutic Riding Center
10370 Barton Road
PO Box 483
Waterford, PA 16441-0483
(814) 474-5276
program@hopehorseback.org

2025 Office use only
Date Received:
Contacted by:
Date:
Comments:
Physician Ref.
Payment:

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ANNUAL RENEWAL APPLICATION, HEALTH INFORMATION AND RELEASE FORM

Please print neatly. Complete both sides of the form.

Rider's Name _____

Date of Birth _____ Age _____

Height _____ (feet and/or inches) Weight _____ Due to safety considerations, any applicant who weighs more than 180 pounds will need approval from the Program Director

Address _____ City/State_____ Zip _____

Phone _____ Cell _____ Email _____

School/Employer _____

Parent/Legal Guardian if applicant is under 18 years of age _____

Address (If different from above) _____

Phone & Email (if different from above) _____

Mother's Employer _____ Occupation _____

Father's Employer _____ Occupation _____

Day/Time Preferences (Please list several choices)

_____

Request for Scholarship application (circle one) YES NO

HEALTH INFORMATION

Diagnosis _____ Date of Onset _____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed)

PHYSICAL FUNCTION (i.e. Mobility skills such as transfers, walking, wheelchair)

_____

PSYCHO/SOCIAL FUNCTION (i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc)

_____

_____

GOALS Update (What would you like to accomplish? i.e. social skills, fine motor skills, ride independently)

_____

_____

HOHB CLIENT LIABILITY AND MEDICAL RELEASE

The undersigned, (as parent or guardian of _____, where applicable or if client is under 18 years of age), in consideration of the instruction given in the horseback riding program furnished by Hope on Horseback Therapeutic Riding Center, does hereby release, discharge, and indemnify HOHB from all claims which the undersigned (or said minor) may have now or in the future resulting from personal injury, death, or property damage to the person or property, caused or in any way growing out of acts of HOHB. It is the understanding that HOHB and its personnel shall take all reasonable precautions regarding the operation of the riding program. I intend to be legally bound by this agreement.

Further, the undersigned authorizes any licensed physician and/or emergency medical personnel to provide any medical/surgical care and/or hospitalization for the client, including anesthetic, which they determine necessary or advisable, pending receipt of specific consent from the undersigned.

_____ Date _____

Applicant's Signature
(Or signature of parent or guardian where applicable, or if applicant is under 18 years of age.)

PHOTO/PUBLICITY RELEASE

I hereby _____ Therapeutic Riding Equestrian Center permission to use my_____
Give/ do not give **own/sons/ daughters**
Name or photographs in its public relations efforts for the primary purpose of promoting The Hope on Horseback Therapeutic Riding Center, and for soliciting financial support for HOHB.

_____ Date _____

Applicant's Signature
(Or signature of parent or guardian where applicable, or if applicant is under 18 years of age.)

Five Week Session Fees:
Level I - $225 Advanced - $250
Classes fill fast. Applications must be accompanied with full fee payment to hold your spot in a class.

HOHB Program Director
PO Box 483
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