

**at Bradford Woods - 5040 State Road 67 North – Martinsville, Indiana 46151**

**765-352-9000**

**Bradford Woods Camp Recreational Riding Registration Packet**

**Horseshoes of Hope Equine Academy** is excited to provide the opportunity for Bradford Woods’s campers to participate in horseback riding activities. In order to provide the safest and highest quality services for your camper, the following forms must be submitted to HoH (address above), **a minimum of (2) weeks prior to camp/check-in:**

\*\*\* All forms MUST be filled out and signed in pen.

( ) **Participant's Application/Health History**

( ) **Participant's Authorization for Emergency Medical Treatment**

( ) **Participant's Medical History & Physician's Statement**

\***Please note that while a physician’s signature is required in order for an individual to be considered eligible for mounted activities, all final decisions are made at the discretion of Path International certified Horseshoes of Hope personnel.**

( ) **Participant's Photo Release and Participants Release and Holds Harmless Agreement**

**\*\* APPLICATIONS FOR RIDING WILL NOT BE ACCEPTED AT CHECK-IN**

Please note thatthose interested in participating must adhere to HoH safety rules including:

* All participants must wear closed heel/closed toe shoes while at the barn.

(Croc, keens, or similar shoes are not appropriate)

* All participants who are riding must wear pants.
* All participants who are riding must wear an ASTM helmet at all times.

(Provided by HoH)

- **For safety reasons, we have a 190 pound weight limit for our riders. Any rider**

**exceeding this limit will have the opportunity to participate in non-riding equine**

**activities.**



**at Bradford Woods - 5040 State Road 67 North – Martinsville, Indiana 46151**

**765-352-9000**

**Participant’s Application & Health History**

**GENERAL INFORMATION**

Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ Height:\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_ Gender: ( ) M ( ) F

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternative #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH HISTORY**

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please indicate current or past special needs in the following areas:*

**PHYSICAL FUNCTION** (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding. Please include assistance required or equipment needed)

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

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**PSYCHO/SOCIAL FUNCTION** (i.e. fears/concerns, companion animals, friend/sibling relationships, leisure

interests, Family structure, support systems)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**MEDICAL: Please provide detail if any of the following exists:**

Seizure Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Controlled: ( ) Y ( ) N Date of last seizure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shunt Present: ( ) Y ( ) N Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last revision:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Participant, Parent, or Legal Guardian**

**Print: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Participant, Parent, or Legal Guardian**

**HORSESHOE OF HOPE EQUINE ACADEMY**

**Authorization for Emergency Medical Treatment Form**

Rider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*\*Please select (1) plan and initial*

**\_\_\_\_\_\_ Consent Plan**

**(initial)**

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 **Horseshoes of Hope Equine Academy** to:

1. Secure and retain medical treatment and transportation if needed.

2. Release client records upon request to the authorized individual or agency involved in

the medical emergency 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 person(s) above is unable to be reached.

Name of Parent or Legal Guardian Providing Consent: (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant, Parent or Legal Guardian

**\_\_\_\_\_\_\_ Non-Consent Plan**

**(initial)**

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.

❏Parent or legal guardian will remain on site at all times during equine assisted activities.

❏In the event emergency treatment/aid is required; I wish the following procedure to take place:

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

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Name of Parent or Legal Guardian Denying Consent: (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Non-Consent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant, Parent or Legal Guardian



**Participant’s Medical History & Physician’s Statement**

**(To be completed by the participant’s physician)**

Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date of Onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_

Past/Prospective Surgeries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seizure Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Controlled: ( ) Y ( ) N Date of Last Seizure: \_\_\_\_\_\_\_\_\_\_\_\_

Shunt Present: ( ) Y ( ) N Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last revision: \_\_\_\_\_\_\_

Special Precautions/Needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobility: Independent Ambulation ( ) Y ( ) N Assisted Ambulation ( ) Y ( ) N

Wheelchair ( ) Y ( ) N Any Braces/Assistive Devices: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*For those with Down Syndrome (Information is REQUIRED):*

AtlantoDens Interval X-rays, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: ( ) + ( ) —

Neurologic Symptoms of Atlanto Axial Instability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please indicate current or past special needs in the following systems/areas, including surgeries:*

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Y** | **N** | **Please describe any special needs marked YES** |
| Auditory |  |  |  |
| Visual |  |  |  |
| Tactile Sensation |  |  |  |
| Speech |  |  |  |
| Cardiac |  |  |  |
| Circulatory |  |  |  |
| Integumentary/Skin |  |  |  |
| Immunity |  |  |  |
| Pulmonary |  |  |  |
| Neurologic |  |  |  |
| Muscular |  |  |  |
| Balance |  |  |  |
| Orthopedic |  |  |  |
| Allergies |  |  |  |
| Learning Disability |  |  |  |
| Cognitive |  |  |  |
| Emotional/Psychological |  |  |  |
| Pain |  |  |  |
| Other |  |  |  |

**Participant’s Medical History & Physician’s Statement**

(To be completed by the participant’s physician)

Please note that the following conditions may be a precautions or contraindication to participating in equine activities.

Therefore, please note whether these conditions are currently present.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Y | N |  | Y | N |
| Orthopedic |  |  | Fire Setting |  |  |
| Atlanto-axial Instability - includes neurologic symptoms |  |  | Hemophilia |  |  |
| Coxarthrosis |  |  | Medical Instability |  |  |
| Cranial Defects |  |  | Migraines |  |  |
| Heterotopic Ossification/Myositis Ossificans |  |  | PVD |  |  |
| Joint subluxation/dislocation |  |  | Respiratory Compromise |  |  |
| Osteoporosis |  |  | Recent Surgeries |  |  |
| Pathologic Fractures |  |  | Substance Abuse |  |  |
| Spinal Joint Fusion/Fixation |  |  | Thought Control Disorders |  |  |
| Spinal Joint Instability/Abnormalities |  |  | Weight Control Disorders |  |  |
| Medical/Psychological |  |  | Neurologic |  |  |
| Exacerbations of Medical Conditions (i.e. RA, MS) |  |  | Hydrocephalus/Shunt |  |  |
| Animal Abuse |  |  | Seizure |  |  |
| Cardiac Condition |  |  | Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia |  |  |
| Physical/Sexual/Emotional Abuse |  |  | Indwelling Catheters/Medical Equipment |  |  |
| Blood Pressure Control |  |  | Skin Breakdown |  |  |
| Dangerous to Self or Others |  |  | Poor Endurance |  |  |

**Please explain any conditions that were marked with a Y above:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that the NARHA center will weigh the medical information given againstthe existing precautions and contraindications. Therefore, I refer this person to the NARHA center for ongoing evaluation to determine eligibility for participation.

**The following signature will only be accepted if it is signed by the participant’s Physician only. PA, NP or Other is NOT acceptable.**

Printed Name/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD/DO

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**at Bradford Woods - 5040 State Road 67 North – Martinsville, Indiana 46151**

**765-352-9000**

**PHOTO RELEASE**

Please **initial** appropriate consent:

\_\_\_\_\_\_ I **DO** consent to and authorize the use and reproduction by Horseshoes of Hope Equine Academy of any and all photographs and any other audio/visual materials taken of me for promotional materials, educational activities, exhibitions or for any other use for the benefit t of the program.

\_\_\_\_\_ I **DO NOT** consent to or authorize the use and reproduction by Horseshoes of Hope Equine Academy of any photographs or other audio/visual materials taken of me while participating in equine assisted activity programs at the facility.

**RELEASE AND HOLD HARMLESS AGREEMENT**

The program **at Horseshoes of Hope Equine Academy** provides therapeutic horseback riding for children and adults. Volunteers and horses are carefully selected and trained and safety equipment is required for all riders since horseback riding is a risk exercise.

No student will be accepted for riding instruction and no volunteer accepted for service until this form has been **READ, UNDERSTOOD, COMPLETED AND SIGNED** by the parent(s) or guardian(s) of a minor, or if the student or volunteer is of legal age and sound mind, by the student or volunteer.

Although participation in the program is under strict supervision and every effort is made to avoid injury or accident, the undersigned acknowledges the inherent risks involved in riding and working around horses. This includes bodily injury from horseback riding or being in close proximity to horses. Among other risks, both horse and rider can be injured in normal use or in competition and schooling. In order to provide this valuable service, **NO LIABILITY** can be accepted by **Horseshoes of Hope Equine Academy, Horseshoes of Hope LLC and John H. Lambert** or any of the organizations or persons connected with the above named facilities.

**IN CONSIDERATION** for the privilege of riding and/or working around horses at **Horseshoes of Hope Equine Academy,** the undersigned, as self, or as parent(s) or guardian(s) of the undersigned minor, jointly and severally, do hereby agree to release, hold harmless and indemnify **Horseshoes of Hope Equine Academy, Horseshoes of Hope LLC and John H. Lambert,** their officers, directors, trustees, agents, employees, representatives, successors and assigns, from all manner of liability, loss, costs, claims, demands and damages of every kind and nature whatsoever, including but not limited to reasonable attorney’s fees, which the undersigned or said minor may now or in the future have against the **Horseshoes of Hope Equine Academy, Horseshoes of Hope LLC, and John H. Lambert,** their officers, directors, trustees, agents, employees, representatives, successors and assigns on account of any accident, damage, injury or illness, physical or mental condition, known or unknown, to the undersigned or said minor, or the treatment thereof, arising as a result of, or in any way connected to acts or incidents occurring at or relating to the **Horseshoes of Hope Equine Academy, Horseshoes of Hope LLC, and John H. Lambert,** their officers, directors, trustees, agents, employees, representatives, successors or assigns, including but not limited to their negligence or gross negligence in rendering the services described above or in any way incidental thereto.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant Name: (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant or Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Parent/Guardian Name: (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip: