Cloud of Witness Ranch Equine Assisted Services Participant Application and Health History

Date of Application: _________________

General Information

Name of Participant: ___________________________ *Preferred Name/Nickname:* ______________

Address: ____

Phone: (____) - ______ - _______ *Alternate Phone:* (____) - ______ - _______

Email: ____

Occupation: _________________ *If student, name of school*: _____________________________

Employer: _____________________ *Phone of work and/or school:* (____) - ______ - _______

(For those under the age of 18)

Parent/Guardian: _______________________________

Address (If different from above): ____

Phone: (____) - ______ - _______ *Alternate Phone:* (____) - ______ - _______

Email: ____

Emergency Contact Information and Authorization for Emergency Medical Treatment

Emergency Contact Information

Name: _________________________________ *Relationship to Participant:* ____________________

Phone: (____) - ______ - _______ *Alternate Phone:* (____) - ______ - _______

Name: _________________________________ *Relationship to Participant:* ____________________

Phone: (____) - ______ - _______ *Alternate Phone:* (____) - ______ - _______

Name of Primary Physician: __________________________________ *Phone:* (____) - ______ - _______

Hospital / Office Address: ____

Authorization for Emergency Medical Treatment

In the event emergency medical treatment if required due to illness or injury while receiving services from or while being on the property of the agency I hereby authorize Cloud of Witness Equine Assisted Services to: secure and retain medical treatment and transportation if needed, release client medical 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 lifesaving by the physician. This provision with only be invoked IF the emergency contacts are unable to be reached. (Please check one)

I Consent: ☐ I Do NOT Consent: ☐ (Please detail alternate procedures on next page)

Signature (If under 18 signature of Parent/Guardian): ____

Non-Consent of Authorization for Emergency Medical Treatment

Please detail alternate procedure you would like put in place: ________________________________

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Liability Release

Indiana State Equine Laws state that: *"Under Indiana law, an equine professional is not liable for any injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities…"*

Cloud of Witness Ranch Equine Assisted Services, Inc ("agency"), this release must be completed by a parent/guardian or participant who is a legally competent adult, eighteen (18) years of age or older. In consideration of permission to use, today and on all future dates, the property, facilities and services ("Facilities") of CLOUD OF WITNESS RANCH EQUINE ASSISTED SERVICES, Inc, I, on behalf of myself, and if applicable, as the parent or legal guardian of the individual named below, I ("we"), acknowledge that a horseback riding program for the impaired carries with it the potential for death, serious injury and property loss. The risks include but are not restricted to damage to soft tissues, bones and joints; therefore, I HEREBY ASSUME THE RISKS OF PARTICIPATING IN THE PROGRAM(S). I HEREBY AGREE TO BE BOUND BY ALL WRITTEN POLICIES, WRITTEN RULES AND WRITTEN REGULATIONS CONCERNING THE USE OF THE FACILITIES OR USE OF EQUIPMENT AS PERIODICALLY FORMULATED, DISTRIBUTED OR POSTED BY THE FACILITY. I, ("we") the undersigned and parents or guardians of participant hereby expressly agree:

1) That horseback riding is a participation sport, and I am fully aware of the risks and hazards involved in or arising from my use of or presence upon the facilities. I hereby assume any and all risks and hazards involved in or arising from my use of or presence upon the facilities, including, without limitation, the risk of bodily injury resulting from falling, collision between myself and another person or stationary object or the negligent or deliberate act of another person, or injury from riding or being near one of the animals;

2) TO RELEASE CLOUD OF WITNESS RANCH EQUINE ASSISTED SERVICES, Inc and any of its successors, assigns, affiliates, officers, directors, employees and agents from, and AGREES NOT TO SUE ANY OR ALL OF THEM on account of or in connection with any claims, causes of action, injuries, damages, costs or expenses arising out of participant's use of or presence upon the Facilities, including, but not limited to, those based on bodily injury, whether or not caused by the negligence or other fault of CLOUD OF WITNESS RANCH EQUINE ASSISTED SERVICES, Inc; 3) In consideration of the privilege of coming upon the real estate and/or of participating in the riding program of CLOUD OF WITNESS RANCH EQUINE ASSISTED SERVICES, Inc, hereby waiver, release and discharge any and all claims for damages for death, personal injury, or property damage, and any other damage which

I may have, or which may subsequently accrue to me, as a result of my interactions with Cloud of Witness Ranch Equine Assisted Services, Inc and of coming upon or about their real estate, including but not restricted to riding and driving horses, hiking, tractor and wagon riding, working, and any other activity on or about their real estate or any place interacting with horses. I hereby agree for myself, and my executors, administrators, heirs, next of kin, successors and assigns ("Other Releasers") to:(a) Waive, release and discharge Cloud of Witness Ranch Equine Assisted Services, Inc, its sponsors, instructors, volunteers and officers, directors and members and any other associates from any and all liability for death, disability, personal injury, personal damage, property theft or actions of any kind which may hereafter accrue to me or Other Releasers as a result of my involvement with coming upon the real estate belonging to James and Martha Lasher, horseback riding, or programs or Agency or my traveling to or from in connection with the program(s); (b) Agree to indemnify and hold harmless the persons or entities mentioned in this release from any and all liabilities or claims made by other individuals or entities as a result of any of my or Other Releaser's, their action including but not restricted to, actions during my involvement with horseback riding or programs of Cloud of Witness Ranch Equine Assisted Services, Inc, its sponsors, instructors, volunteers and officers, directors and members and any other 4.) I HAVE READ AND UNDERSTOOD THIS AGREEMENT. I UNDERSTAND THAT BY MAKING AND SIGNING THIS AGREEMENT, I SURRENDER VALUABLE RIGHTS, INCLUDING, BUT NOT LIMITED TO, MY RIGHT TO SUE. I DO SO FREELY AND VOLUNTARILY. The AWRL shall be construed broadly to provide a release and waiver to the maximum extent permissible under applicable law. I hereby certify that I am eighteen (18) years of age or older and legally competent; or I am the legally competent parent or legally competent guardian of the below named person and have the authority to sign this document. I have read this document, and, I understand its contents.

Signature: ___________________________________ *Date:* ________________

Photograph Release

I hereby consent to and authorize the use and reproduction by Cloud of Witness Equine Assisted Services of any and all photographs and any other audiovisual materials taken of me/my ward for promotional material, educational activities, social media, website or for any other use for the benefit of the program.

(Please Check one) ***I Consent*** ______ ***I Do NOT Consent*** _____

Signature (Parent/Guardian if under 18): ____

Health History / Physicians Release for Participation

ALL PAGES OF THIS FORM MUST BE UPDATED ANNUALLY BY THE PHYSICIAN'S OFFICE

Form Completion Date:___________________ Participants Date of Birth: ______________________
Name:____
Address:____
Name of Parent or Guardian:____
Diagnosis:____
____

Medication names and doses: ____
____

Allergies: ____
Tetanus Shot Current? Yes No

Height ________ Weight ________

********FOR INDIVIDUALS WITH DOWNS SYNDROME*********

Full flexion and extension X-rays for Atlantoaxial Instability (AAI) is required within 5 years prior to entering Cloud of Witness Equine Assisted Services program. Annual physical examination should reveal no symptoms of AAI. Follow up X-rays should be every 10 years after.

NO INDIVIDUAL MAY RIDE WITH POSITIVE SYMPTOMS OF AAI.

Cervical X-ray for AAI Negative _________ Date _____________ Doctor's Initials _______

MEDICAL HISTORY *Please circle Yes or No for each of the following conditions. The presence of a condition will need to be further evaluated before it is determined if it is appropriate for the client to receive riding instruction. This is for the client's safety.*

Spinal Fusion: Yes No

Location and type____
Past/Prospective
Surgeries:____
____

Medications:
____
____
____
____
____
____
____

Seizure Type: ____

Controlled: Yes No

Date of Last Seizure: ___________________________

Shunt Present: Yes No Date of last revision: ____________________

Special Precautions / Needs:

____
____
____
____
____
____
____

Mobility

Independent Ambulation: Yes No

Assisted Ambulation: Yes No

Wheelchair: Yes No

Braces/Assistive Devices:

____
____

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities

	Y	***N***	***Comments***
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

My signature indicates I have found no medical reason that this individual can not participate in Cloud of Witness Equine Assisted Services programs.

Name/Title: ___________________________________ MD DO NP PA Other
Signature:______________________________________

Date:___________________________

Address: ____
Phone (_______) _____________________________

License/UPIN Number: ________________________

During riding activities all riders are required to wear boots or shoes with a ½" heel. Please indicate below if this individual should be exempt from this rule because their braces or other physical issue prevent them from wearing any shoes except tennis/athletic type shoes.

____

____

Signature

____

Date __________________________