Participant's Application & Health History

Name of Participant:____

DOB: _______________Age: ___________Height: __________Weight: __________Gender: M F

Address: ____

Phone: ______________Email: ________________________Alternative #: ___________________

Employer/School: ____

Address: ____

Phone:____

Parent/Legal Guardian: ____

Caregivers: ____

Address (if different from above): ____

Phone: ____

Referral Source: ____

Phone: ____

How did you hear about the program? ____

HEALTH HISTORY Diagnosis: ____

Date of Onset:_________________

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

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

MEDICATIONS (include prescription and over-the-counter; name, dose and frequency) ____________
____
____
____
____
____

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

PHYSICAL FUNCTION (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding) ____
____
____
____
____

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

GOALS (i.e. why are you applying for participation? What would you like to accomplish?____________
____
____
____
____
____

Signature: ____Date: ___________________________

LIABILITY RELEASE FORM

In consideration of the services provided at **CHAPS CENTER, INC.** its managing partners, board members, employees, representatives, agents and associates (hereinafter referred to as **Provider**). I hereby agree to release, indemnify, and discharge "Provider" on behalf of myself, my children, my parents, my heirs, assigns, personal representative and estate as follows:

1. I, ______________________________acknowledge that horseback riding, caring for horses, and all therapeutic and learning/ self- discovery and/or psychotherapeutic activities involving horses entail known and unanticipated risks which could result in physical or emotional injury, paralysis, death, or damage to me, to property or to third parties. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity.

The risks include, among other things: loss of control, collisions; horses, irrespective of their previous behavior and characteristics, may act or react unpredictably based upon instinct, fright, or lack of proper control by rider or handler, latent or apparent defects or conditions in equipment, animals or property, acts of other students in this activity, adverse weather conditions; contact with plants, insects, or animals; my own physical conditions or my own acts or omissions; the conditions of remote roads, trails, waterways, or terrain, and accidents connected with their use; first-aid, emergency treatment or other services rendered; consumption of food and drink.

Furthermore, PROVIDER seeks safety, but they are not infallible. They might be unaware of a student's fitness or abilities. They might misjudge weather, the elements or the terrain. They may give adequate warnings or instructions and the equipment being used might malfunction.

2. I expressly agree and promise to accept and assume all of the risks existing in this activity. My or my child participation in this activity is purely voluntary, and elects to participation in spite of the risks.

3. I hereby voluntarily release, forever discharge, and agree to indemnify and hold harmless PROVIDER from any and all claims, demands, or causes of action, which are in any way connected with my or my child's participation in this activity or my or my child's use of PROVIDERS equipment or facilities, including any such claims which allege negligent acts or omissions of PROVIDER.

4. Should PROVIDER or anyone acting on their behalf be required to incur attorney's fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.

5. I certify that I have adequate insurance to cover any injury or damage I or my child may cause or suffer while participating or else I agree to bear the costs of such injury or damage myself. I further certify that neither I nor my child has any medical or physical conditions, which could interfere with my safety in this activity, or else I am willing to assume-and bear the cost of-all risks that may be created, directly or indirectly, by any such condition.

CHAPS
CENTER FOR HORSEMANSHIP AND PERSONAL SUCCESS

6. In the event that I file a lawsuit against PROVIDER, I agree to do so solely in the state of Florida, and I further agree that the substantive law of that state shall apply in that action without regard to the "conflict of laws" rules of that state. I agree that if any portion of this agreement is found to be void or unenforceable, the remaining portion shall remain in full force and effect.

By signing this document, I acknowledge that if anyone is hurt or property is damaged during my or my child's participation in this activity, I may be found by a court of law to have waived my or my child's right to maintain a lawsuit against PROVIDER on the basis of any claim from any claim from which I have released them herein.

EQUINE WARNING: Under Florida Law, an equine activity sponsor or equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.

I have had sufficient opportunity to read this entire document. I have read and understood it, and I agree to be bound by its terms.

Print Student/ Participant Name:____

_______________________________________ _________________________________
Parent, Guardian, Teacher signature Date

Print Name of Guardian or Teacher Participant_____________________________________

Address:____

Phone:_________________________________ Email:_________________________________

Emergency Contact:____
Name Phone

PHOTO /VIDEO RELEASE (check one)

☐ I DO consent to and authorize the use and reproduction by Chaps Center Inc. of any and all photographs and any other audio/visual materials taken of us for promotional material, education activities, and exhibitions or for any other use for the benefit of the program.

☐ I DO NOT give consent to use the above use of photo or video graphic materials.

Signature:	**Date:**

PARTICIPANT REGISTRATION INFORMATION – PLEASE WRITE CLEARLY IN INK

Name:		**DOB:**
Mailing Address:		
City:	**County:**	**Zip:**
Home:	**Mobil:**	
Work:	**Email:**	

CAREGIVER INFORMATION

Parent / Guardian:		**Phone:**
Caregiver:		**Phone:**
Mailing Address:		
City:	**County:**	**Zip:**
Home:	**Mobil:**	
Work:	**Email:**	

AUTHORIZATION OF EMERGENCY MEDICAL TREATMENT (check one)

In the event of 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 Chaps Center to 1.)Secure and retain medical treatment and transportation if needed and 2.)Release client records upon request to the authorized individual or agency involved in the emergency.

Emergency contact:	**Relationship:**
Physician Name:	**Phone:**
Health Insurance Company:	
Policy Info:	

☐ I Give 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. 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.

☐ I do not give 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 procedure to take place:

____

____

Applicants Signature Date:

____

Signature of Parent/Guardian Date:

CHAPS SAFETY GUIDELINES

Welcome to Chaps! We are glad you are here. After reading the material, please sign where indicated showing that you understand and are in agreement with the policies and procedures of our organization.

- The 10 acres adjacent to Chaps is a private residence – no trespassing please.
- Designated Chaps parking is located at the rear of the property.
- Anyone riding or handling a horse on Chaps property must have a signed waiver on file. Waivers are available online or from the instructors.
- If you wish to observe the session, please sit at the tables and chairs located under the wonderful shade tree. Please keep the conversation levels down so there will be no distractions for the student.
- OPTION TO PARKING AND WAITING WHILE CLASS IS IN SESSION: Lake Jessup Wilderness Park And Boat Ramp is located just down the street from Chaps on South Sanford Avenue. There are walking trails, picnic tables, and covered areas. A great place to let the kids let off some steam!
- All riders must wear an ASTM approved helmets at all times while riding on the property.
- Under no circumstance is a child allowed to retrieve a horse in a turnout without adult supervision.
- Children under the age of 16 must be under the direct supervision of a parent or adult designated by a parent at all times while on Chaps property.
- For safety reasons, no one is allowed on the horse trail without permission from a staff member.
- Do not hand feed treats to horses without permission. Some horses, such as Mr. Jed are allergic to corn. He blows up like a little balloon – it's not pretty....

THANK YOU FOR YOUR COOPERATION IN MAKING CHAPS CENTER A SAFE AND HAPPY FARM!

I have read the preceding information and will agree to adhere to the safety practices and facility guidelines while on property with my family and/or clients.

____
Student Name/Signature

____
Parent/Guardian Name/Signature

____
Date

Give this letter to your physician for permission to participate.

Date: ____________________________

Dear Health Care Provider:

Your patient ____
(participant's name)

is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability - include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia

Other

Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - e.g., Photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (e.g., RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance.

Sincerely,

CHAPS Center, Inc. Staff

Participant's Medical History & Physician's Statement

Participant: ____DOB: _________Height: ________Weight: ________
Address: ____
Diagnosis: ____ Date of Onset: _______________
Past/Prospective Surgeries: ____
Medications: ____
Seizure Type: _____________________________________Controlled: Y N Date of Last Seizure:_____________
Shunt Present: Y N Date of last revision: ____
Special Precautions/Needs: ____
____
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices: ____
For those with Down Syndrome: Neurologic Symptoms of Atlantoaxial Instability: ______ Present ______ Absent

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			

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 PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

Name/Title: ____MD DO NP PA Other ___________

Signature: ____Date: _________________

Address: ____

Phone: (___) __________________________License/UPIN Number: _________________________________