Horses for Healing

PARTICIPANT REGISTRATION & EMERGENCY CONTACT INFORMATION

Participant_____ Date of Birth_____

Age_____ Gender: M F

Diagnosis _____

Weight_____

Address_____City_____
_____State_____ Zip Code_____ County _____

Participant's School or Employer:_____Email:_____

Ethnicity _____ Phone Number:_____

Referral Source:_____

Is participant a military Veteran? Yes No

Mother's/Guardian Information: (minor or dependent adult only)

Name_____

Mailing Address_____

City _____ State_____ Zip _____
Email_____ Cell Phone_____

Home Phone_____ Work Phone_____

Place of Employment_____

Occupation _____

Best way to get a hold of you (Please circle one): Email Mobile Phone Text Message Home Phone Work Phone

Father's Information: (minor or dependent adult only)

Name_____

Mailing Address_____

City _____ State_____ Zip _____

Email_____

Cell Phone_____ Home Phone_____ Work Phone_____

Place of Employment_____

Occupation _____

Best way to get a hold of you (Please circle one): Email Mobile Phone Text Message Home Phone Work Phone

Individual Responsible for payment:

Name_____

Mailing Address_____

City _____ State_____ Zip _____

Email_____

Cell Phone_____ Home Phone_____

Relationship to Participant: _____

Caregiver Name (if applicable):_____Phone Number: _____

Emergency contact_____

Relationship:_____Phone_____

Physician's Name_____Phone_____

Preferred MedicalFacility_____

Allergies:_____

Current Medications:_____

Significant Medical History:

_____

_____

_____

I have listed all significant medical information to the best of my knowledge.

Signature of Participant or Parent/Guardian: _____ Date _____

GOALS for IMPROVED DAILY LIVING SKILLS Please include equestrian skills and daily living skills

1.

2.

3.

4.

5.

Hobbies and other interests:

Previous riding or horse-related experience: □ None □ Minimal □ Moderate □ Extensive If previous riding experience: □ Independent □ Spotter/Leader □ Sidewalker(s)

Describe Previous Equine Experiences Year Started Duration

Notes on prior riding:

Horses for Healing Participant Liability Release, Photo Release &

Medical Consent Plan Liability Release

_____(Participant's name) would like to participate in the Horses for Healing Equine program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Horses for Healing, its Board of Directors, Instructors, Therapists, Aides, Volunteers, and Employees for any or all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Horses for Healing Programs.

WARNING - Under Nebraska Law, an 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, pursuant to sections 25-21,249 to 25-21,253.

Date:_____ Signature_____
(Participant, Parent or Guardian)

Photo Release

I do consent and authorize I do not consent to the use and reproduction by Horses for Healing of any or all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities or any other use for the benefit of the program.

Date:_____Signature_____
(Participant, Parent or Guardian)

Medical 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 parent/guardian or emergency contact is unable to be reached.

Date_____ Consent Signature_____
(Participant, Parent or Guardian) Parent/Guardian
Name_____Address_____

Home Phone_____________________________Work Phone_____________________________

Cell Phone_____________________________