AGAPE
UNBRIDLED HOPE

AGAPE SOUTH PHONE: (317) 775-9101
WWW.AGAPERIDING.ORG

BRADFORD WOODS SUMMER CAMP PARTICIPANT AGAPE REGISTRATION FOR:

_____
(Name of Participant)

SECTION I. SUMMER CAMP PARTICIPANT INFORMATION

Name: _____ Date of Birth: ___/___/___ Age: ___

Address: _____ City/State: _____

County: _____ Zip: _____ Ethnicity: _____ Gender: M/F

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Place of Employment: _____

Are you presently a student? Yes/No If yes, name of school: _____

Does the participant currently have an IEP? Yes/No

SECTION II. ADULT/GUARDIAN INFORMATION IF PARTICIPANT LISTED IN SECTION I IS UNDER THE AGE OF EIGHTEEN (18) OR UNDER A LEGAL DISABILITY

Name: _____ Father/Mother/Guardian

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Place of Employment: _____ Email Address: _____

Please name any caregivers/phone numbers who may transport or be responsible for participant:

SECTION III. PHOTO AND MEDIA CONSENT

Agape Therapeutic Riding Resources, Inc. requests that the above-listed Agape Equine Participant consent to and authorize the use and reproduction by Agape Therapeutic Riding Resources, Inc. of any and all photographs and any other audio-visual materials taken of the above-listed Agape Equine Participant for publication in promotion material, educational activities, exhibitions, publications, broadcasts, website and any other use which promotes Agape Therapeutic Riding Resources, Inc. and its programs.

Please check only one: ____ I do consent. ____ I do **not** consent.

_____ Date: _____
Signature of Participant or Parent/Guardian

SECTION IV. EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Participant: _____
(Primary Contact)

Telephone Numbers: _____

Name: _____ Relationship to Participant: _____
(Secondary Contact)

Telephone Number(s): _____

Primary Physician Name/Telephone Number(s): _____

Preferred Medical Facility: _____

Health Insurance Provider: _____ Policy/Identification Number: _____

Information for Emergency Medical Providers: _____
(Such as allergies, medications, preexisting medical conditions)

Agape Emergency Medical Policy

In the event emergency medical aid/treatment is required for a Participant, Agape Therapeutic Riding Resources, Inc. will:

1. Contact 911, state the nature of the emergency and request that an ambulance be sent to the scene of the occurrence;
2. Contact the person(s) listed above in the priority listed; and
3. Provide the information listed above to emergency medical providers.

I have read and acknowledge the Agape Emergency Medical Policy.

_____ Date: _____
Signature of Participant or Parent/Guardian

EQUINE ACTIVITY RELEASE, ASSUMPTION OF RISK AND AGREEMENT TO INDEMNIFY

This *Equine Activity Release, Assumption of Risk and Agreement to Indemnify* (the "Agreement") is hereby entered by on the dates indicated below.

A. Scope of Services Provided. Agape Therapeutic Riding Resources, Inc. ("Agape") is a not-for-profit organization that sponsors, organizes and/or provides facilities for activities involving equines including, but not limited to, therapeutic riding and equine-facilitated learning programs with such activities taking place both on the premises owned by Agape ("Premises") and at other locations within the State of Indiana ("Locations") (collectively "Agape Equine Activities").

B. Inherent Risks of Equine Activities. The undersigned expressly understands that certain dangers or conditions are an integral part of such Agape Equine Activities including but not limited to: i) The propensity of an equine to behave in ways that may result in injury, harm, or death to persons on or around the equine, ii) The unpredictability of an equine's reaction to such things as sound, sudden movement, unfamiliar objects, people, or other animals, iii) Hazards such as surface and subsurface conditions, iv) Collisions with other equines or objects and v) The potential of a person involved in Agape Equine Activities to act in a negligent manner that may contribute to injury to that person and/or other persons, such as by failing to maintain control over an equine. **The undersigned expressly understands and agrees that such dangers or conditions exist whether a person is: i) personally engaging in Agape Equine Activities, ii) a spectator of Agape Equine Activities or iii) entering, departing or being on the Premises or Locations where Agape Equine Activities are taking place and that by doing any of these actions, such a person is a "Participant."**

C. Assumption of Risk, Release and Waiver of Liability and Indemnity Agreement. In consideration of Agape allowing the undersigned, as well as those persons for whom the undersigned has listed herein, to be a Participant and with an understanding of the Inherent Risks of Equine Activities as set forth in Paragraph B above, the undersigned, individually and on behalf of each persons listed herein by the undersigned, hereby assumes all such risks and forever releases, waives, discharges and covenants not to sue Agape Therapeutic Riding Resources, Inc. (including its directors, officers, shareholders, employees, agents, representatives, volunteers, insurers, affiliates, successors, assigns and others acting on Agape Therapeutic Riding Resources, Inc.'s behalf including, without limitation, independent contractors such as trainers, instructors, veterinary personnel, farriers, equine care providers and maintenance personnel) (collectively the "Released Parties") from all liability, loss, claims, demands, possible causes of action, court costs, attorneys' fees and other expenses, known or unknown, anticipated or unanticipated, that may result from any loss, damage or injury (including death) to the person or property of i) the undersigned and ii) each person listed herein by the undersigned which, in any way, results from, or arises in connection with, or relates to, any Agape Equine Activity whether caused by the negligence of the Released Parties or others. The undersigned further hereby agree to indemnify and hold harmless the Released Parties and each of them from any and all loss, liability, damage or cost they may incur due to the undersigned and each person listed herein by the undersigned being a Participant whether caused by the negligence of the Released Parties or otherwise.

The undersigned agrees that the Indemnification Agreement shall also apply as to any loss, liability, damage or cost incurred by persons and their property who have not executed an *Equine Activity Release, Assumption of All Risk and Agreement to Indemnify* but who the undersigned invited or otherwise encouraged to be a Participant.

D. Binding Effect. This Agreement shall be binding upon the heirs, executors, administrators, agents, insurers and assigns of the undersigned and shall inure to the benefit of and may be enforced

by the Released Parties. **If this Agreement is executed for and on behalf of a Participant who is under the age of eighteen (18) or under some other legal disability, the undersigned hereby represents and warrants that he or she is in fact the legal parent or guardian of said Participant with full rights of custody and control and that this Agreement and all terms contained herein is given on behalf of and is intended to be binding upon said Participant, his/her heirs, executors, administrators, agents, insurers and assigns.**

E. <u>Complete Agreement, Choice of Law, Venue and Attorneys Fees</u>. The terms of this Agreement contain the entire agreement of the parties as to the subject matter set forth herein and shall be governed by the laws of the State of Indiana. In the event any provision of this Agreement is deemed to be invalid or unenforceable by any court or administrative agency of competent jurisdiction, then the Agreement shall be deemed to be restricted in scope or otherwise modified to the extent necessary to render its provisions valid and enforceable. The parties agree that Hamilton County, Indiana is the exclusive venue for any legal proceedings arising from or related to this Agreement and the Released Parties shall be entitled to recover the costs incurred (including reasonable attorney's fees) from the undersigned in the event that any legal action (regardless of whether a lawsuit is filed) is required to enforce this Agreement.

I HAVE FULLY READ AND FULLY UNDERSTAND THIS EQUINE ACTIVITY RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF ALL RISK AND AGREEMENT TO INDEMNIFY. I UNDERSTAND THAT, BY SIGNING THIS DOCUMENT, I MAY BE WAIVING AND RELEASING CERTAIN IMPORTANT RIGHTS WHICH I MIGHT HAVE IF I DID NOT SIGN THIS AGREEMENT. I AM SIGNING THIS DOCUMENT VOLUNTARILY AND WITHOUT ANY COERCION.

ADULT/GUARDIAN(S) FULL NAME

_____
Signature and Date

_____
Printed Name

_____
Signature and Date

_____
Printed Name

EACH PARTICIPANT UNDER THE AGE OF 18 OR OTHERWISE UNDER A LEGAL DISABILITY FOR WHOM EACH ADULT PARTICIPANT IS SIGNING (Please Print):

_____
Name

_____
Name

_____
Name

WARNING

Under Indiana 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.

SECTION VI. HEALTH HISTORY

PARTICIPANT INFORMATION

Participant Name: _____ DOB: _____

Name of Parent(s)/Guardian(s): _____Phone:_____

Diagnosis/Disability (Required): _____Date of Onset (if applicable): _____
Height: _____ Weight: _____ Male/Female (Circle One)

DIAGNOSIS & CONDITIONS

If the answer to any of the following health questions on this page is yes, a Physician's Release form (p.7) is required.

Does the participant have (Circle Yes or No):

Crutches	Yes	No	G-tube	Yes	No
Walker	Yes	No	Catheter	Yes	No
Braces	Yes	No	Shunt	Yes	No
Wheelchair	Yes	No			

Has the participant ever been treated for any of the following? If yes, check the box, provide date of occurrence and details:

Yes	Condition	Date	Details
	Down Syndrome		
	Spinal condition (i.e. injury, scoliosis, fusion, Spina Bifida)		
	Brain condition (i.e. Cerebral Palsy, stroke)		
	Bleeding or clotting disorders		
	Diabetes		
	Fatigue & Immune Deficiency		
	Joint & bones complications (i.e. hip dysplasia, arthritis)		
	Epilepsy		
	Muscular		
	Heart condition		
	Neurological condition		
	Pulmonary condition		
	Skin break down or pressure sores		

In the past 12 months, has the participant (Circle Yes or No):

Been hospitalized for any serious injury, condition or surgery?	Yes	No
Experienced loss of consciousness, including seizures?	Yes	No
Experienced a psychotic crisis?	Yes	No
Need assistance to maintain an upright sitting position or control of his/her head?	Yes	No
Been necessary to restrict activities due to medical reasons? **If yes, please explain:*	Yes	No

GENERAL HEALTH AND FUNCTION

Please describe any conditions or issues in the following areas:

	Details
Hearing	
Vision	
Speech	
Circulation	
Cognitive Development	
Emotional or psychological	
Behavior	
Other	

Please list if applicable:
Medications_____

Medical devices (feeding tubes, shunts, etc.)_____

Allergies_____

Tetanus Shot No Yes Date of Shot_____

Does the participant have an (circle yes or no):

Asthma	Yes	No
EpiPen	Yes	No
Inhaler	Yes	No

SIGNATURE

I hereby affirm that, to the best of my knowledge, the health history information is complete and correct.

Name of person completing this form: _____Date:_____

Signature: _____Relationship to Participant: _____

Please return this form by mail/fax to:
Bradford Woods, Attn: RT Summer Camp, 5040 SR 67 N, Martinsville, IN 46151
Fax (765) 349-1086

PHYSICIAN'S RELEASE FORM FOR AGAPE

This form is required if: ❒ Participant has Down Syndrome AND/OR ❒ If one or more of the health questions on pg. 5(section vi) of the Health History Form are 'Yes'. Please return this form by mail/fax to: IU Bradford Woods, Attn: RT Summer Camp, 5040 SR 67 N, Martinsville, IN 45151; Fax (765) 349-1086.

PARTICIPANT INFORMATION

Participant Name: _____DOB: _____

Name of Parent(s)/Guardian(s): _____Phone:_____

PHYSICIAN'S REPORT

Medical	**Normal**	**If not normal, please explain**
Appearance and affect		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Pulses		
Heart		
Lungs		
Abdomen		
Skin		
Neurologic		
Musculoskeletal		
Neck		
Back		
Upper Extremities		
Lower Extremities		

FOR PERSONS WITH DOWN SYNDROME
Neurologic exam reveals symptoms consistent with atlantoaxial instability? Yes No Date of Exam: **No individual may ride at Agape with positive symptoms of AAI.*

Jarring Toleration

For activities at Agape such as horseback riding, can the participant tolerate jarring (circle one)? Yes No

If no, please explain:

All riding and equine-assisted activities are closely supervised by trained therapeutic riding instructors. Upon reviewing this information and all possible contraindications, please indicate your medical opinion by checking one of the boxes below:

☐ **Full Participation**: Individual may participate in all equine-assisted activities, including riding.

☐ **Partial Participation**: Individual **cannot** participate in the following:

___Horseback riding; ___Grooming; ___Other:_____

☐ **No Participation**: Individual **cannot** participate in any equine-assisted activities.

PHYSICIAN'S RELEASE

I have examined the above-named participant and, given the participant's diagnosis and health history, this person does not present apparent clinical contraindications for equine sports. I understand that Agape will weigh the medical information provided against the existing precautions and contraindications; therefore, I refer this person to Agape for ongoing evaluation to determine eligibility for participation.

Physician's Signature: **Date:**

Physician's Name (please print): **Phone:**

Address/City/Zip: