



16497 Snyder Road
Chagrin Falls, OH 44023
440.708.0013
Fax: 440.708.0029
www.fieldstonefarmtrc.com

REGISTRATION

Participant: _____ Date of Birth: _____ Age: _____

Street: _____

City: _____ County: _____ Zip Code: _____

Primary Phone: _____ cell home **(choose one)**

For adult participants: Secondary Phone: _____ cell home work **(choose one)**

Email: _____

School or Institution presently attending: _____

Participant is a **(choose one)**: Minor Adult w/a legal guardian Independent adult

For grant writing purposes only, please indicate participant's ethnic background. Check any that apply:

Caucasian Asian Hispanic/Latino African American Native American Other

For minors or adults with legal guardians:

Parent or Guardian Name: _____ Occupation: _____

Employer: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Other Parent or Guardian Name: _____ Occupation: _____

Employer: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Other Parent or Guardian Home Address (if different): _____

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

Participant Name: _____ Date of Birth: _____

IN CASE OF EMERGENCY

In the event of a medical emergency, Fieldstone Farm will provide basic first aid and/or call 911 and will disclose all available health care information to emergency medical personnel.

Please list **two** Emergency Contact names/phones:

Emergency Contact Name: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

Please note any LIFE THREATENING allergies (bees, asthma, medications):

PHOTO RELEASE

For valuable consideration, the receipt of which from Fieldstone Farm Therapeutic Riding Center and PATH Intl. is hereby acknowledged, the undersigned hereby grants to Fieldstone Farm permission to take, or have taken, still and moving photographs, videos and films including television pictures of myself and/or the participant for use by Fieldstone Farm, its advertising agencies, news media, and any other persons involved with Fieldstone Farm and its programs including PATH Intl., to use and reproduce the photographs, films, videos and pictures and to circulate and publicize the same by any means deemed appropriate by Fieldstone Farm, including without limitation newspapers, television media, online media, brochures, pamphlets, magazines, instructional materials, books and clinical materials.

No inducements or promises have been made to me to secure my signature to this release other than the intention of Fieldstone Farm to use or cause to be used such photographs, films, videos and pictures for the primary purpose of promoting and aiding Fieldstone Farm and/or PATH Intl. and its programs.

I DO consent

I DO NOT consent

Date: _____ Signature: _____

Fieldstone Farm
RELEASE AND HOLD HARMLESS AGREEMENT

The undersigned agrees on behalf of himself/herself, the undersigned's minor child and/or the undersigned's representatives, heirs and assigns ("Releasing Parties") to the following:

A. Fieldstone Farm Therapeutic Riding Center ("Fieldstone Farm") has fully explained to him/her the risks involved with horseback riding, carriage driving, showing horses, horse-related activities and/or being in close proximity of horses. These risks include but are not limited to: 1. the propensity of a horse to behave in ways that may result in bodily injury; physical harm, permanent disability; death, or loss to persons around the horses, including without limitation, the rider, driver, handler; and spectator; 2. the unpredictability of horse's reaction to sound, sudden movement, unfamiliar objects, persons, or other animals, which reaction may include but is not limited to changing speed or direction at will, shifting its weight, bucking, rearing, kicking, biting, running from danger, stepping on a person's feet, pushing or shoving a person; 3. hazards, including but not limited to surface and subsurface conditions, 4. collision with another horse, animal, person or object; and 5. the potential of the Releasing Parties, or any other person involved in an equine activity to act in a negligent manner that may contribute to injury, death permanent disability, or loss to any of the Releasing Parties or the other persons, including, but not limited to failing to maintain control over a horse or failing to act within the ability of the participant. The Releasing Parties each further understands that the horse is a prey animal and regardless of its calm nature and training, the horse may revert to its natural instinct to fight or flee when frightened, which may result in injury, death, permanent disability, or loss to you or other persons. By signing this Release, the Releasing Parties each assumes all of the dangers and risks associated with horse activities and being in close proximity of horses, including those risks enumerated above.

B. In consideration of the privilege of riding, handling, and working around and being in close proximity to horses at Fieldstone Farm located at 16497 Snyder Rd., Chagrin Falls, Ohio, the Releasing Parties each releases, discharges and promises not to sue Fieldstone Farm, or any of its employees, officers, directors, trustees, members, volunteers, successors and assigns for any loss, damage, injury, including death or cost to any of the Releasing Parties or persons accompanying any of the Releasing Parties arising out of riding, handling or being in close proximity of horses and equine activities, including without limitation failing to wear a protective helmet and or use of saddles, bridles, helmets, equipment and gear provided by Fieldstone Farm or any other person or entity. The Releasing Parties also each agrees to discharge, release and promises not to sue Fieldstone Farm from any claim arising from Fieldstone Farm's training or selecting of the horses, maintenance, care, fit or adjustment of saddles or bridles, instruction on riding and related skills or leading or supervising Releasing Parties in his/her riding and other equine activities, including without limitation non-riding activities such as handling, bathing and grooming horses.

C. The Releasing Parties each agrees to indemnify and hold harmless Fieldstone Farm, its employees, volunteers, trustees, directors, officers, successors, assigns and students from and against any loss, liability, damage, expense or costs including attorney fees that it may incur or incurs arising out of or in any way connected with the Releasing Parties' participation in equestrian activities, including without limitation, handling or riding of horses or being in close proximity to a horse or due to the failure to wear a helmet when riding or handling and/ or use of saddles, bridles, equipment in connection with the equestrian activities. This indemnification provision shall survive the signing of this Release.

D. The Equine Liability Law, Ohio Revised Code Section 2305.321 generally states in part: *Equine (Horse) Activity Sponsor is not liable in damages in tort or other civil action or harm that and Equine Participant allegedly sustains during an equine activity and that results from inherent risk of equine activity.*

Signature

Date

Print Name

Name of minor child (if applicable)

HEALTH HISTORY

Participant's Name: _____ Date of Birth (mo/day/yr): _____
 Name of Parent(s) or Guardians: _____ Primary Phone: _____
 Height: (ft.) _____ (in.) _____ Weight: _____ Male Female

DIAGNOSIS or DISABILITY (Required): _____

Date of Onset (year): _____

If the answer to any of the following HEALTH QUESTIONS is YES, a Physician's Release form (p.7) is required.

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

Yes		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		
	Joint complications such as hip dysplasia		
	Epilepsy		
	Heart condition		
	Neurological condition (including seizures)		
	Pulmonary condition		
	Skin break down or pressure sores		
	Medical shunt		

In the past 12 months, has the participant:

Experienced loss of consciousness, including seizures?	Circle One	
	Yes	No
Experienced a psychotic crisis?	Yes	No
Been hospitalized for any serious injury, condition or surgery?	Yes	No
In the past 12 months, has it been necessary to restrict the participant's activities due to medical reasons?	Yes	No
If Yes, provide details: _____		
Does the participant need assistance to maintain an upright sitting position or control his/her head?	Yes	No

A Physician Release (pg. 7) is **required** if the participant is a hippotherapy client or if you answered yes to **any** of the health questions above.

GENERAL HEALTH AND FUNCTION

Please describe any conditions or issues in the following areas:

	NORMAL	IF ABNORMAL, PLEASE EXPLAIN
Hearing		
Vision		
Speech		
Immune deficiency		
Circulation		
Cognitive Development		
Pulmonary		
Fatigue or limited endurance		
Muscular		
Orthopedic (incl. spine & joints)		
Emotional or Psychological		
Behavior		
Broken bones		
Other		

Please list if applicable:

Medications: _____

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

Allergies: _____

Does the participant have or use:

Circle One

Asthma	Yes	No
EpiPen	Yes	No
Inhaler	Yes	No

Walker	Yes	No	
Crutches	Yes	No	
Wheelchair	Yes	No	
Body brace of any type	Yes	No	Describe

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: _____

IMPORTANT: Fieldstone Farm reserves the right to request additional information and/or an evaluation by the participant's licensed medical professional prior to or during the course of equine-assisted programming and/or to restrict or offer alternative activities until such information or evaluation is procured.

Questions? Please contact Winni Spisak at 440.708.0013 x146 or wspisak@fieldstonefarmtrc.com



STUDENT GOAL CHECKLIST

(To be completed by student, parent, guardian, teacher or therapist)

Student Name: _____ Age: _____

Diagnosis: _____

Our instructors would like to know the important life goals that you or your student are working toward. They use this information to structure their lesson plans and activities.

Please select up to **5 major goals that are important to you and/or your child across the three categories.** Please prioritize items with #1 being the most important goal.

Physical Goals	Social & Recreational Goals	Cognitive/Educational Goals
_____ Improved balance	_____ Cooperation	_____ Color identification
_____ Improved posture	_____ Participation	_____ Shape recognition
_____ General coordination	_____ Sportsmanship	_____ Letter recognition
_____ Head control	_____ Enjoyment	_____ Word recognition
_____ Trunk control	_____ Confidence/self-esteem	_____ Verbalization
_____ Strength	_____ Communication skills	_____ Vocab. Expansion
_____ Gross motor skills	_____ Attention (increase/decrease)	_____ Sequencing
_____ Fine motor skills	_____ Responsibility	_____ Spatial Awareness
_____ Decrease tactile defensiveness	_____ Social skills	_____ Reading skills
_____ Improved muscle tone	_____ Independence	_____ Math Skills
_____ Increased range of motion	_____ Other:	_____ Other:
_____ Other:		

What major life goals is the client working toward? :

If necessary, what methods of behavior modification, communication, etc. would you prefer the instructor use when working with this client? Please describe:

Completed by: _____

Date: _____



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PHYSICIAN'S RELEASE

This form is required if:

- Participant has **Down syndrome**
- If one or more of the HEALTH QUESTIONS on page 4 are answered YES
- Participant is a Hippotherapy client

Participant Name: _____ Date of Birth: _____
 Parent/Guardian Name: _____ Phone: _____

PHYSICIAN'S REPORT

MEDICAL	NORMAL	IF ABNORMAL, 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		
Does this patient have symptoms consistent with atlantoaxial instability? Yes No DATE OF EXAM: _____		

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 Fieldstone Farm will weigh the medical information provided against the existing precautions and contraindications; therefore, I refer this person to Fieldstone Farm for ongoing evaluation to determine eligibility for participation.

Physician's Signature: _____ Date: _____

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

Address/City/Zip: _____

Questions? Please contact Winni Spisak at 440.708.0013 x146 or wspisak@fieldstonefarmtrc.com

If participant has experienced seizure activity within the past 12 months, the following SEIZURE EVALUATION FORM is required. Participants or their parents or guardians may wish to consult with their physician when completing the following:

SEIZURE EVALUATION FORM

Instructions: Participants/parent/guardians/treating physicians – please complete this form including as much information as possible. Since riding and working around horses is a risk activity, conditions that increase that risk are carefully analyzed. The safety of all participants, volunteers and horses is considered.

Participant Name _____
Physician Treating Seizures _____ Physician's Phone _____
Type of Seizure (if more than one, please list all types) _____
Date of Last Seizure _____ Frequency of seizures _____
Duration of Each Seizure _____
Typical Causes of Seizure Activity _____

Seizure activity indicators (aura, behaviors or manifestations of oncoming seizure activity)

After Affect

- During a seizure, I / my child/patient:
- May stare briefly (How long?) _____
- May walk around
- May perform aimless activities
- May suddenly cry / fall / become rigid, followed by muscle jerks / saliva on lips / bluish skin color
- May experience loss of bladder or bowel control
- May be confused, have a headache, be fatigued; followed by full return of consciousness
- Other. Please explain:

Are you/is your child/patient able to know and express when a seizure may occur? What are the signs?

Should you/your child experience a seizure while at Fieldstone Farm, beyond employing general first aid, what actions do you suggest we take?

- Do nothing
- Dismount from horse
- Allow _____ minutes to rest and reorient
- Report observations to parents/guardians immediately
- Send note home to parent/guardian
- Other. Please specify:

Signature of Participant/Parent/Guardian

Date