FIELDSTONE FARM

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 or home ***(circle one)***

For adult participants: Secondary Phone:_____cell, home or work ***(circle one)***

Primary Email for Billing and Communication_____

School or Institution presently attending: _____

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

How did you hear about us?_____

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

Caucasian☐ Asian☐ Hispanic/Latino☐ African American☐ Native American☐ Other☐

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: _____

Questions? Please contact Katy Flint at 440.708.0013 x145 or kflint@fieldstonefarmtrc.com

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 it 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

HEALTH HISTORY

Participant's name: _____ Date of Birth: _____

Height (Required): _____ **Weight (Required):** _____ Gender: _____

DIAGNOSIS or DISABILITY (Required): _____

Date of Onset (year): _____

If the answer to any of the following HEALTH QUESTIONS is YES, and you plan to participate in any programs on-site, a Physician's Release form (p.6) 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 including pacemakers		
	Neurological condition i.e. hydrocephalous, mitochondrial disorder		
	Pulmonary condition		
	Skin break down or pressure sores		
	Medical shunt or any type of feeding tube		
	Any seizure activity for any reason		

In the past 12 months, has the participant experienced:	***Circle one***	
1. Loss of consciousness, including seizures:	Yes	No
2. Hospitalization for a mental health crisis:	Yes	No
3. Been hospitalized for any serious injury, condition or surgery	Yes	No
4. Been necessary to restrict the participant's activities due to medical reasons:	Yes	No
5. Requires assistance to maintain an upright sitting position or control his/her head:	Yes	No
6. A medical device such as an insulin pump, catheter, or colostomy bag:	Yes	No

If ***Yes*** to any of the questions above please provide date and details: _____

GENERAL HEALTH AND FUNCTION

Please describe any conditions or issues in the following areas:

	NORMAL	IF NOT WITHIN NORMAL RANGE, 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: _____

Allergies: _____

Does the participant have or use:

Asthma	Yes or No
EpiPen	Yes or No
Inhaler	Yes or No

	Circle One	
Walker	Yes or No	
Crutches	Yes or No	
Wheelchair	Yes or No	
Body brace of any type	Yes or 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 Katy Flint at 440.708.0013 x145 or kflint@fieldstonefarmtrc.com

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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 (if not within normal ranges, 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: _____

SEIZURE EVALUATION FORM

If participant has experienced seizure activity within the past 12 months, the following form in its entirety is required. Participants or their parents or guardians are encouraged to consult with their physician when completing the following:

Instructions: Students/parent/guardians – 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.

Seizure paperwork must be completed every 6 months for all participants who have had a seizure or seizure activity in the calendar year. Seizure paperwork must be completed annually for all participants who have had a seizure or seizure activity more than 12 months ago.

Participant Name _____

Emergency Contact Name _____

Emergency Contact Home Phone _____

Emergency Contact Work Phone _____

Emergency Contact Cell Phone _____

Type of Seizure (if more than one, please list all types) _____

_____

_____

Are you under the care and treatment of a physician?

- ☐ Yes
- ☐ No

Date of Last Seizure _____Frequency of seizures _____

Duration of Average Seizure _____

Typical Causes of Seizure Activity _____

_____

_____

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

_____

Are you able to know when a seizure may occur? Can you express it? What are the signs?

_____

_____

During a seizure, I may:

□ 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:

After Affect _____

_____

Current Medications _____

_____

Please note most recent seizure activity and incidents with comments (add additional rows as necessary)

Date/time	Details	Care provided
Date/time	Details	Care provided
Date/time	Details	Care provided
Date/time	Details	Care provided

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

❒ Call 9-1-1

❒ Report observations to parents/guardians immediately ❒ Allow _____ minutes to rest and reorient

_____

Student/Parent/Guardian Date FFTRC Staff Date