

**FIELDSTONE FARM**

*A Horse Can Change A Life*

16497 Snyder Road  
Chagrin Falls, OH 44023  
440.708.0013  
Fax: 440.708.0029  
[programs@fieldstonefarm.org](mailto:programs@fieldstonefarm.org)

**2026 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

For new students: 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

Is the participant or their immediate family (father, mother, sibling, spouse) a member of the U.S. military, active reserves or a veteran? (**Circle one**):    Yes    No

Branch of service: \_\_\_\_\_ Relationship to Family member: \_\_\_\_\_

**For minors or adults with legal guardians (Required):**

Parent or Guardian Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address if different than participant: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_

Other Parent or Guardian Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address if different than participant or first guardian: \_\_\_\_\_

Relationship to participant: \_\_\_\_\_

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):

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***PHOTORELEASE***

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: \_\_\_\_\_

## ***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.*

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Signature

Date

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Print Name

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Name of minor child or Adult with legal guardianship (if applicable)

# ***HEALTH HISTORY***

Participant's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height (Required): \_\_\_\_\_ Weight (Required): \_\_\_\_\_

Gender (Circle one, Required): Woman/Girl Man/Boy Transgender Nonbinary/Nonconforming Other Prefer Not to Share  
 Student Preferred Pronoun: \_\_\_\_\_

List ALL Diagnoses or Disabilities (Required): \_\_\_\_\_ Date of Onset (year): \_\_\_\_\_

If the answer to any of the following HEALTH QUESTIONS is YES, 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   |      | Date of most recent seizure: |
|     | 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                          |      |                              |

**In the past 12 months**, has the participant experienced:

- |  |     |
|--|-----|
| 1. Loss of consciousness, including seizures:  | Yes |
| 2. Any seizure activity for any reason   | Yes |
| 3. Hospitalization for any serious injury, condition or surgery                            | Yes |
| 4. Activity restrictions due to medical reasons:   | Yes |
| 5. The need for assistance to maintain an upright sitting position or control of the head: | Yes |
| 6. A medical device such as an insulin pump, catheter, or colostomy bag:                   | Yes |

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

**And complete a required Physician's Release** (pg. 6)

**GENERAL HEALTH AND FUNCTION**

Has the participant ever been treated for the following? If yes, please provide details:

|  | Yes | Details |
|--|-----|---------|
| 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                                      |     |         |
| Hospitalization for a mental health crisis |     |         |

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Does the participant have or use:

|         |     |
|---------|-----|
| Asthma  | Yes |
| EpiPen  | Yes |
| Inhaler | Yes |
|         |     |

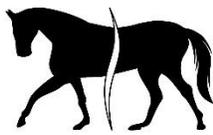
|                        |     |          |
|------------------------|-----|----------|
| Walker                 | Yes |          |
| Crutches               | Yes |          |
| Wheelchair             | Yes |          |
| Body brace of any type | Yes | Describe |

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.



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**PHYSICIAN'S RELEASE**

This form is required if:

- Participant has **Down syndrome or seizure activity**
- If one or more of the HEALTH QUESTIONS on page 4 are answered YES

Participant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

|   |
|---|
| <b>PHYSICIAN'S REPORT MEDICAL</b> (if not within normal ranges,                             |
| Appearance and Affect   |
| Eyes/Ears/Nose/Throat   |
| Lymph Nodes   |
| Pulses  |
| Heart   |
| Lungs   |
| Abdomen   |
| Skin  |
| Neurologic  |
| <b>MUSCULOSKELETAL</b>  |
| Neck  |
| Back  |
| Upper Extremities   |
| Lower Extremities   |
| <b>FOR PERSONS WITH DOWN SYNDROME</b>   |
| Does this patient have symptoms consistent with atlantoaxial instability?      Yes      No  |
| <b>FOR PERSONS WITH SEIZURE ACTIVITY</b>  |
| Does this patient still require close supervision due to seizure symptoms?      Yes      No |

**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***

**Complete the following form if the participant has experienced seizure activity within the past 3 years.**

Seizure paperwork must be completed every 6 months for all participants who have had a seizure or seizure activity in the prior 12 month period. If the participant has been seizure-free for more than 3 years, Fieldstone Farm will not follow our active seizure-related procedures such as providing a volunteer spotter during mounted lessons.

**Instructions:** Please complete this form including as much information as possible. Since 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.

Student's Name \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Parent/Guardian Preferred Phone \_\_\_\_\_

You are encouraged to consult with the physician who manages your or your child's seizure care when completing the following:

**Type of Seizure (if more than one, please list all types)** \_\_\_\_\_

Are you/Is your child under the care and treatment of a seizure physician (e.g a neurologist)?

- Yes
- No

Are you/Is your child taking medication to control the seizures?

- Yes
- No

**Date of Last Seizure (Required):** \_\_\_\_\_ 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 / is your child able to know when a seizure may occur? Can you / they express it? What are the signs?

**During a seizure, I / my child:**

- May stare briefly (How long? \_\_\_\_\_ )
- May walk around
- May perform aimless activities
- May suddenly cry
- May suddenly fall
- May suddenly become rigid, followed by muscle jerks
- May suddenly have saliva on lips
- May suddenly have 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 |

Should you / your child 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      Fieldstone Farm Staff      Date

# *Fieldstone Farm Student Goal Checklist*

Student name: \_\_\_\_\_

Form completed by: \_\_\_\_\_

Our instructors would like to know the important life goal that the rider/participant/you is working towards. This information helps us to structure our lesson plans. Examples: walking without assistance, independent living, decision making, etc.

1. What is a major life goal?

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2. Please rank the goal categories below as you feel they are important to you/your student. **Rank your top three categories 1 through 3** with 1 being the most important.

\_\_\_\_\_ **Physical Goals** (balance, coordination, strength, etc.)

\_\_\_\_\_ **Social Goals** (socialization, confidence, enjoyment, etc.)

\_\_\_\_\_ **Cognitive Goals** (readiness skills, decision making, concentration, etc.)

\_\_\_\_\_ **Independent Living Goals** (effective communication, being a part of a community, self-advocacy, etc.)

3. Other goals for this participant during their time at the farm:

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If needed, what behavior modification techniques would you suggest or recommend instructors use in the barn and during lesson if the participant is experiencing a challenge?

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