

RAEMELTON EQUINE ACTIVITIES REGISTRATION

PARTICIPANT INFORMATION:

Date _____

Last Name

First Name

Address

() _____
Contact Phone Number

City

State

Zip Code

Sex: F _____ M _____

Last 4 Digits of Social Security Number

Date of Birth

Height

Weight (Riding Weight Limit 185 LB)

Has participant previously participated in equine activities? _____

If yes, where and what type of activity? _____

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

For demographic data only, please indicate participant's ethnic background. Check all that apply:

___ Caucasian ___ Asian ___ Hispanic/Latino ___ African American ___ Native American ___ Other ___ Prefer not to answer

PARENT/GUARDIAN & EMERGENCY CONTACT INFORMATION:

Name

Relationship

Primary (Preferred) Phone Number

Alternate Phone

Emergency Contact? Yes or No

Name

Relationship

Primary (Preferred) Phone Number

Alternate Phone

Emergency Contact? Yes or No

Does the participant have **LIFE THREATENING ALLERGIES** (meds, bee stings, latex, etc.): Yes _____ No _____

If yes, please list

FOR MINOR RIDERS ONLY:

School presently attending: _____ Grade _____

Father's Name _____

Mother's Name _____

Occupation _____

Occupation _____

Business Phone _____

Business Phone _____

Cell Phone _____

Cell Phone _____

Email _____

Email _____

PROGRAM SELECTION

SESSION

Therapeutic Riding _____ EFL _____ Camp _____

Spring _____ Summer _____ Fall _____ Winter _____

PAYMENT OPTIONS

_____ **Option 1: Full Session Payment**

Therapeutic Riding, Camp, or EFL (10wk) \$325.00 _____ EFL Winter only (6 wk)\$195.00 _____

If Agency Pay, please list here: _____

_____ **Option 2: Three Equal Payments**

Therapeutic Riding/Camp/EFL (10wk) \$109/\$109/\$107 _____ EFL Winter (6wk) \$65/\$65/\$65 _____
(First payment due prior to the start of session, remaining due on the 4th and 8th classes)

_____ **Option 3: Rider Scholarship**

A financial aid application must be filled out for each session

Acceptance of full or partial scholarships are based on the Review Committee approval of the Scholarship Application

AN ANNUAL MEDICAL HISTORY & PHYSICIAN STATEMENT MUST BE COMPLETED AND SIGNED ANNUALLY BY A PHYSICIAN FOR THERAPEUTIC RIDING AND CAMP ONLY.

The medical history and physician statement is included in this packet and all information on the statement must be filled out **only** by the physician. Participants with Down syndrome, in addition to the medical history and physician statement, will need an annual x-ray.

A REGISTRATION PACKET MUST BE FILLED OUT EACH YEAR.

PHOTO RELEASE

I hereby consent to and authorize the use and reproduction by Raemelton Therapeutic Equestrian Center of any and all photographs and any other audiovisual materials taken of me, my son or daughter or my ward for promotional printed materials, educational activities or for any other use for the benefit of Raemelton Therapeutic Equestrian Center’s program(s).

Signature

Relationship to Rider

Date

DECLARATION OF INTENT

I hereby acknowledge that the aforementioned Rider is applying for acceptance into a Riding Program at Raemelton Therapeutic Equestrian Center. I have a completed and signed Liability Waiver and Emergency Medical Forms for this Rider. I understand that participation in this Program is dependent upon compliance by the Rider with all policies, procedures and safety requirements of the Equestrian Center. Failure to comply may result in dismissal from the Program.

The appropriate program selection and desired method of payment are indicated in this document. I agree that I will be responsible for the cost of the selected program. Payment options and/or any financial assistance for which this Rider qualifies will be arranged by me and approved by the Raemelton Therapeutic Equestrian Center staff prior to the start of the session.

My signature herein indicates my acceptance of the above-specified stipulations. If the Rider is a minor, permission is also granted for full participation in any and all activities related to the selected Program.

Signature

Relationship to Rider

Date

WAIVER OF LIABILITY AND CONSENT FOR INDIVIDUALS TO PARTICIPATE IN RAEMELTON THERAPEUTIC EQUESTRIAN CENTER PROGRAMS

I hereby grant consent for the undersigned Equine Activity Participant (as such term is defined in Ohio Revised Code 2305.321, Section A(3) and referred herein as "Participant") to participate in the Raemelon Therapeutic Equestrian Center program.

In addition, this document constitutes a written Waiver of Liability, as defined and described in Ohio Revised Code 2305.321, Sections C(1) and C(2), for the benefit of the Raemelon Therapeutic Equestrian Center, Inc., its Affiliates and its duly Authorized Agents. Pursuant to Ohio Revised Code 2305.321, section C(2)a, the undersigned acknowledge that there are inherent risks associated with Equine Activities including, but not limited to:

- ✓ The property of an Equine to behave in ways that may result in injury, death or loss to persons on or around the Equine;
- ✓ The unpredictability of an Equine's reaction to sounds, sudden movement, unfamiliar objects, persons or other animals;
- ✓ Hazards including but not limited to, surface or subsurface conditions;
- ✓ A collision with another Equine, another animal, a person or an object;
- ✓ The potential of an Equine Activity Participant to act in a negligent manner that may contribute to injury, death or loss to the person of the participant or to other persons, including but not limited to, failing to maintain control over an Equine or failing to act within the ability of the Participant.

I have read and understand the above inherent risks, have had the opportunity to have my questions answered, and understand the potential benefits and alternatives to this activity.

Participant's Signature

Date

Participant's Date of Birth

Please complete section below if Participant is a Minor or under Guardianship.

Parent/Guardian Signature (If different from authorized signature)

Date

Parent/Guardian Printed Name

Authorized Signature

Date

Authorized Person's Printed Name & Title

SEIZURE EVALUATION FORM

If participant has **experienced seizure activity within the past 12 months**, this
SEIZURE EVALUATION FORM IS REQUIRED.

Consultation with the participant's physician is recommended when completing this form.

To Participants/Parents/Guardians/Treating Physicians: Please complete this form including as much information as possible. Riding and working around horses is an at risk activity. Health conditions that increase that risk need to be carefully analyzed. The safety of all participants, volunteers and horses is our utmost priority and careful consideration of all involved is mandatory.

Participant Name

Physician Treating Seizures (_____) Physician's Phone

Date(s) of last seizure(s) Type(s) of last seizure - please list all

Frequency of seizure(s) Duration of each seizure

Typical cause(s) of seizure activity, if known

Seizure activity indicator(s) - aura, behaviors or manifestations of oncoming seizure activity

Is the participant able to express when a seizure may occur?

After effects of seizure

During a seizure, I/my child/patient may:

- Stare briefly
- Walk around
- Perform aimless activities
- Suddenly cry / fall / become rigid, followed by muscle jerks / saliva on lips / bluish skin color
- Experience loss of bladder or bowel control
- Be confused, have a headache, be fatigued; followed by full return to consciousness
- Other, please explain: _____

Participant's/Parent's/Guardian's Signature **Relationship to Participant** **Date**

Participant's/Parent's/Guardian's Printed Name