



Registration Form Equine-Assisted Learning

REGISTRATION FORM

Please Print In Boxes

PARTICIPANT NAME(s) If two siblings use same form for both.	<i>Please complete applicable sections</i>		
	DOB	NAME OF SCHOOL	GRADE

PARENT/GUARDIAN NAME	ADDRESS (street, city, state, zip)	Home Phone	Work Phone	Cell / Pager

Family Email Address(s): _____

Are you in need of any special accommodations to ensure you and/or your child's safety while participating in this program?
If yes, please explain.

✍		
SIGNATURE OF PARTICIPANT	PRINT NAME	DATE
✍		
SIGNATURE OF PARTICIPANT	PRINT NAME	DATE

IF A MINOR, SIGNATURES OF BOTH PARENTS/GUARDIAN ARE REQUIRED:

✍	✍	
SIGNATURE OF PARENT/GUARDIAN	SIGNATURE OF PARENT/GUARDIAN	DATE

What EAL Program Are You Registering For?

Tell us how you heard about the H.O.R.S.E. program.

- Southwestern Bell Yellow Pages
 Brochure
 Internet
 Doctor
 Friend or Family member
 Magazine or newspaper _____
 Counselor _____
 Other _____





Activity Agreement


As a chosen participant in this growth and learning activity, I agree to the following as they relate to my activities at Eveningstar Equestrian Ranch, and Big River Ranch or any other premises or facilities that may be used by H.O.R.S.E. from time to time:


1. I will not be under the influence of alcohol or illegal drugs nor will I bring any on the property at any time.
2. I will not bring fire arms or weapons of any type on the property.
3. I will not smoke on the property. This includes but is not limited to: in or around the barn, in any arenas or other activity center or anywhere else on the grounds. Those that accompany me understand that if they wish to do so, they may smoke in their vehicle but that no tobacco remains will be disposed of outside the vehicle on either of the properties.
4. I will respect our workspace that includes the barn, the grounds and the arena located on the property.
5. I will be respectful of the horse owners, their horses, any domestic animals and their property while on the grounds of the property.
6. I will not run or act in a manner that may frighten the horses or be distracting to the individuals that I encounter on the property, knowing that to do so may endanger the safety of myself and others.
7. I agree to follow all rules of H.O.R.S.E., Inc. and understand that my failure to follow said rules may constitute grounds for refusal of further service to me by H.O.R.S.E., Inc.

8. Other: _____

 _____
Signature of Participant(s) _____
Date

 _____
Signature of Participant(s) _____
Date
If a minor, signatures of both parents/guardian is required:

 _____
Signature of Parent/Guardian _____
Date

 _____
Signature of Parent/Guardian _____
Date



CONSENT TO PARTICIPATE/PARTICIPANT AGREEMENT, RELEASE & ACKNOWLEDGEMENT OF RISK

I/We, _____, am agreeing to participate in equine assisted learning (EAL) opportunities, through H.O.R.S.E. Inc. I/we have read all forms, releases and paperwork provided to me/us. This paperwork (hereinafter referred to as “the contract”), totals 13 pages and includes:

- 1) Registration Form EAL Adult or Child
- 2) Activity Agreement
- 3) Consent to Participate Agreement
- 4) Participant Agreement, Release, and Acknowledgement of Risk
- 5) Confidential Medical History Information/Authorization for Emergency Medical Treatment
- 6) Non-Consent For Emergency Medical Treatment
- 7) Video and Photograph Release
- 8) Summary of Notice of Privacy Practices

I/We agree that I/we have read, reviewed and understand the State of Missouri’s Equine Activity Liability Act Warning, which states:

MISSOURI WARNING

UNDER MISSOURI 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, PURSUANT TO THE REVISED STATUTES OF MISSOURI, RSMO 537.325.

I/We understand that for the purpose of these activities, H.O.R.S.E. employees, contractors and/or volunteers are considered agents of the organization and shall be considered “equine professionals” directed under the guidance of a lead equine professional.

My/Our participation in EAL program activities per this Agreement is deemed “equine activities” under the above statute.

Signature

Date

Signature

Date

Signature of Parent/Guardians (if applicable)

Date

Signature of Parent/Guardians (if applicable)

Date

Review and sign following Participant Agreement, Release & Acknowledgement of Risk.



PARTICIPANT AGREEMENT, RELEASE, AND ACKNOWLEDGEMENT OF RISK

In consideration of my receiving the services from H.O.R.S.E. Incorporated, Brenda J. Wright, individually and d/b/a Eveningstar Equestrian Ranch, 19021 Long Grove Road, Higginsville, MO 64037, and/or Big River Ranch, 20111 Goodloe Orchard Road, Lexington, MO 64067, and/or from any of their agents, owners, officers, directors, volunteers, participants, employees, independent contractors or other premise owners allowing their facilities to be used for the purposes of H.O.R.S.E., and/or any and all other persons or entities acting in any capacity on their behalf (hereinafter collectively referred to as and/or "the Released Parties"), I hereby agree to release, indemnify, and discharge H.O.R.S.E. and the Released Parties, on behalf of myself, my children, my parents, my heirs, assigns, personal representatives and estate as follows:

1. I acknowledge that horseback riding, caring for horses, and all therapeutic activities involving horses entail known and unanticipated risks which could result in physical or emotional injury, paralysis, death, or injury to myself or third parties, or damage to property. I understand that such risks are inherent to the natural behavior of horses to act in an unpredictable manner and thus cannot be controlled or eliminated. These risks include, but are not limited to: (1) the propensity of a horse to behave in ways, i.e. running, bucking, biting, kicking, shying, stumbling, rearing, falling or stepping on, that may result in an injury, harm or death to persons on or around them; (2) the unpredictability of a horse's reaction to such things as sounds, sudden movement and unfamiliar objects, persons, or other animals; (3) certain hazards such as surface and subsurface conditions; (4) collisions with other horses or objects; and (5) the potential of a participant to act in a negligent manner that may contribute to injury to the participant or others, such as failing to maintain control over the horse or not acting within such participant's ability."
2. I expressly agree and promise to accept and assume all of these risks, whether named or unnamed, which potentially exist in this activity. My participation in this activity is purely voluntary, and I elect to participate in spite of the risks.
3. I hereby voluntarily release, forever discharge, and agree to indemnify and hold harmless H.O.R.S.E., Inc., and the Released Parties, from any and all claims, demands, and/or causes of action, which are in any way connected with my participation in this activity or my use of H.O.R.S.E.'s equipment or facilities, including any such Claims which allege the negligent acts or omissions of H.O.R.S.E. and/or the Released Parties.
4. Should H.O.R.S.E. or the Released Parties be required to incur attorney's fees and costs to enforce any provision of this agreement, I agree to indemnify H.O.R.S.E. for same.
5. I certify that I have adequate insurance to cover any injury or damage I may cause or suffer while participating, or else confirm my agreement to personally be responsible for all costs of such injury or damage.
6. I agree that any litigation arising out of this Agreement shall be brought solely in the state of Missouri. I agree that if any portion of this agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect.
7. I agree that I have read, reviewed and understand the State of Missouri's Equine Activity Liability Act Warning which states:

MISSOURI WARNING

UNDER MISSOURI 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, PURSUANT TO THE REVISED STATUTES OF MISSOURI, RSMO 537.325.

I understand that for the purposes of this agreement H.O.R.S.E. Inc., the Released Parties and all persons acting as agents or representatives of H.O.R.S.E. Inc. and/or the Released Parties shall be considered "equine professionals".

By signing this document, I acknowledge that if I am hurt or any of my property is damaged during my participation in this activity, I waive my right to assert any claim or bring any legal action against H.O.R.S.E. Inc. and/or the Released Parties, even for those claims allegedly involving their negligence. I have been given sufficient opportunity to read this entire document and/or to have it reviewed by legal counsel prior to my signature. I have read and understood it, and I agree to be bound by its terms.

✍️Signature of Participant: _____ Print Name: _____

✍️Signature of Participant: _____ Print Name: _____

Address: _____

Phone(s): _____ Date: _____

Signature of Both Parents or Guardian (if applicable):

✍️ _____
Signature of Parent/Guardian Date

✍️ _____
Signature of Parent/Guardian Date

Confidential Medical History Information



With regards to your physical well being and in order for H.O.R.S.E. Inc. to ensure that the activities that you might be engaged in will be suitable for your over all health, the following "confidential medical history information should be filled out.

Print Name(s): _____ DOB: _____

Address: _____

(if a minor) Print Name of Parent/Guardian(s): _____

Current Tetanus Shot(s) Yes No Date: _____ Height: _____ Weight: _____

Does the participant(s) have any health issues that would not allow them to safely engage in any physical activity including but not limited to running, jumping, lifting less than 50 lbs., exposure to dusty conditions, animal hair and dandruff? If so please identify those conditions and/or consult with H.O.R.S.E. Inc. as to a way to ensure participant's health safety during the activities. Please list any of these conditions below, if none, please list N/A and initial.

CONSENT: Authorization for Emergency Medical Treatment

The undersigned hereby grants to H.O.R.S.E., Inc., and/or Brenda J. Wright, and/or any agents representing the organization H.O.R.S.E. the authority to secure emergency medical treatment for Participant if the undersigned and/or Participant's emergency contact person is unavailable to make such decisions.

Print Participant Name(s): _____ Phone: _____

Address: _____

Emergency Contacts:

Contact: _____ Phone: _____

Contact: _____ Phone: _____

Physician: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Company: _____

I have filled out this medical information sheet to the best of my knowledge. I understand that the information provided will be kept confidential. I also understand that equine assisted learning may be physically challenging and I take full responsibility for deciding whether or not I, or my minor child(ren), should participate. By signing this form, I am accepting the physical nature of EAL and am agreeing to participate or agreeing for my minor child to participate.

Participant Signature _____ Date _____

Participant Signature _____ Date _____

If participant is a minor both signatures of parents/guardians required:

Signature of Parent/Guardian _____ Date _____

Address: _____ Phone: _____

Signature of Parent/Guardian _____ Date _____

Address: _____ Phone: _____

PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD. Failure to include a copy of your card may interfere with our ability to secure emergency medical treatment.

IF YOU DO NOT WANT TO AUTHORIZE EMERGENCY MEDICAL TREATMENT BE SURE TO SIGN THIS PAGE AND LEAVE THE SECOND HALF OF PAGE 5 BLANK. IF YOU HAVE SELECTED TO ISSUE AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT DO NOT SIGN THIS PAGE.

NON-CONSENT***NON-CONSENT*****NON-CONSENT*******

Non- Consent ForEmergency Medical Treatment

If the undersigned **DOES NOT DESIRE TO GRANT** H.O.R.S.E. Inc. and/or Brenda J. Wright, or any agents representing the organization H.O.R.S.E. the authority to secure emergency medical treatment for Participant if the undersigned and/or Participant’s emergency contact person is unavailable to make such decisions, please initial the box below and state on the reverse side of this form the procedures to be followed if the Participant becomes ill or is involved in an accident and the undersigned is unavailable.

IDO NOT CONSENT to Brenda J. Wright or any agents representing the organization H.O.R.S.E. obtaining health care information or making health care decisions concerning the participant.

✗ Signature: _____ Date: _____

(Print) Name: _____

✗ Signature: _____ Date: _____

(Print) Name: _____

If a minor, signatures of both parents/guardian is required:

✗ _____
 Signature of Parent/Guardian _____
 Date

✗ _____
 Signature of Parent/Guardian _____
 Date



Video and Photograph Release

The below signed individuals agree to be photographed and/or videotaped by the H.O.R.S.E. program while engaging in Equine Assisted Therapy and/or Equine Assisted Learning with the understanding that said media may be used for the purpose of training and marketing. This includes but is not limited to, printed material, web site material, and promotional presentations.

Signature of Participant: _____ Print Name: _____

Date: _____

Signature of Participant's Parent/Guardian if participant is under 18 years of age.

Print Name

Date: _____

Signature of Participant's Parent/Guardian if participant is under 18 years of age.

Print Name

Date: _____

No, please do not photograph or video myself or my child.

SUMMARY OF NOTICE OF PRIVACY PRACTICES

The following summary is associated with the HIPPA notice in document H.O.R.S.E. HIPPA Notice of Privacy Practices and More and is a HIPPA requirement in regard to requesting your health information and your privacy.

This notice describes how medical information about you may used and disclosed and how you can get access to this information. Please read the Notice of Privacy Practices carefully.

On this page we have summarized the document H.O.R.S.E. HIPPA Notice of Privacy Practices and More. For a complete description of your rights and our responsibilities, please review the entire notice within the above document. If you have not received this document please contact Brenda J. Wright, address and phone number listed below.

Your Rights. Your rights related to your medical information are as follows:

- The right to request restrictions on the way we use your medical information;
- The right to request and receive information from us in a different way or manner;
- The right to review your medical information;
- The right to request that we amend your medical information; and
- The right to know how we have used or disclosed your medical information.

We will not use or disclose your health information without your authorization, except as otherwise described in this Notice of Privacy Practices.



What We Are Required to Do. It is our responsibility to:

- Protect your medical information;
- Provide you with our Notice of Privacy Practices; and
- Abide by the terms of this Notice.

We can change our privacy practices. If we decide to change them, we will change this Notice and post the changes at our facility and on our website. If you have any questions and/or would like additional information, please contact the following individual:

CONTACT: Brenda J. Wright
 ADDRESS: 19021 Long Grove Rd. Higginsville, MO 64037
 PHONE: 660.584.7892

Acknowledgement. I acknowledge that I have been provided with H.O.R.S.E. HIPPA Notice of Privacy Practices and More document.

 _____ SIGNATURE OF CLIENT/PARTICIPANT	 PRINT NAME	 DATE
 _____ SIGNATURE OF CLIENT/PARTICIPANT	 PRINT NAME	 DATE

IF A MINOR, SIGNATURES OF BOTH PARENTS/GUARDIAN ARE REQUIRED:

 _____ SIGNATURE OF PARENT/GUARDIAN	 _____ SIGNATURE OF PARENT/GUARDIAN	 DATE
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FOR OFFICE USE ONLY

Participant was unwilling/unable to sign Acknowledgement. Reason: _____
 Staff Initials: _____ DATE _____