INFINITY
EQUINE THERAPY
Post Office Box 92, Closter, New Jersey 07624
http://infinityequine.org

Year _____

PARTICIPANT REGISTRATION FORM

Participant

Name _____
Address _____
Telephone – Home _____ ***Mobile*** _____ **Email** _____
Date of Birth _____ ***Height**** _____ ***Weight**** _____ ***M/F*** *(please indicate)* ___
**This information is required to match the horse to the participant*

Parent/Legal Guardian/Caregiver

Name _____
Address ***(if different from participant's)*** _____
Telephone – Home _____ ***Mobile*** _____ **Email** _____
In an emergency, which number should be called? _____

Medical History

Allergies ***(specify)*** _____
Asthma? Y__ N__ If yes, restrictions: _____
Diabetes? Y___ N___ Date of last tetanus shot _____
Medications ***(please list all regularly taken medications)*** _____
_____
Any reaction/allergies to penicillin or any other drugs? Y___ N___ If yes, please list below:
_____
Recent accidents or injuries? Y__ N__ If "yes," give date/type of injury _____
_____
Orthopedic problems? Y__ N__ If "yes," describe: _____
_____
Neurologic problems? Seizures___ Dizziness___ Fainting___**
Other medical Issues ***(please describe in detail)*** _____
_____
_____
Down syndrome? Y___ N___**

***If you answered "yes" to these questions, you must submit a Supplemental Medical Form.*

Any restrictions on participating in sports? Y___ N____
If yes, describe _____

Please Note: Instructors may request that a Supplemental Medical Form be submitted at any time.

GENERAL BACKGROUND INFORMATION

Cognitive Level _____

Able to understand language? Y ____ N ____ Able to express self verbally Y _____ N _____

Psychosocial concerns (emotional/social patterns) _____
_____
_____

Are you or the participant's current day program using any behavior modification program? Y ___ N___ If yes, please describe _____

Does participant have any fears? Y____ N___ If yes, please describe the fear(s) and participant's response to them: _____
_____

How does participant respond to feelings of frustration and/or anger? What coping mechanisms help him/her deal with these feelings? _____
_____

Previous riding experience _____

Please describe any family and/or participant concerns, goals and any other information that will help us to plan participant's program: _____
_____
_____

Photo Release I hereby ____ **give** my permission ____ **do not give** my permission for images of my child/ward/myself to be taken during activity sessions, by video, photo or digital camera, to be used solely for the purposes of promotional material and publications, and I waive all rights of compensation or ownership of such images on behalf of myself and my child or ward.

Parent/Guardian *(please initial)* _____

The undersigned acknowledges that he/she has read this Application in its entirety and understands the terms of the Liability Release. The undersigned also certifies that the information on this form is true and complete as of the date below and to the best of the undersigned's knowledge.

Signature of Parent/Legal Guardian _____ **Date** _____
Print name _____

SIGN ONLY IF PARTICIPANT IS 18 YEARS OR OLDER AND DOES NOT HAVE A LEGAL GUARDIAN
Signature _____ **Date:** _____
Print name_____

INFINITY
EQUINE THERAPY
Post Office Box 92, Closter, New Jersey 07624
http://infinityequine.org

UPDATE TO PARTICIPANT REGISTRATION FORM

For returning participants only

Participant

Please enter any changes to this information

Name _____

Address _____

Telephone – Home _____ ***Mobile*** _____ **Email** _____

Date of Birth _____ ***Height:**** _____ ***Weight:**** _____ ***M/F*** *(please indicate)* ___

**This information is required to match the horse to the participant*

Parent/Legal Guardian/Caregiver

Please enter any changes to this information

Name _____

Address _____

Telephone – Home _____ ***Mobile*** _____ **Email** _____

In an emergency, which number should be called? _____

In the space below, please describe in detail any changes in participant's health since the participant's last compete application, including any changes in medication, abilities, behavior, diagnoses, and medical treatments/procedures. You may use this space to provide any other information (whether medical or not) that you believe IET needs to know in order to assist the participant. If there have been no changes, please write "no change." _____

_____

_____

_____

I certify that the information on this form is true and complete as of the date below and to the best of my knowledge.

Signature: _____ Date: _____

Print name: _____

INFINITY EQUINE THERAPY
Post Office Box 92, Closter, New Jersey 07624
http://infinityequine.org

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Please indicate: **Participant *(if over 18)*** _____ **Parent/Legal Guardian** ____ **Volunteer**_____
Name _____
Address _____
Telephone – Home _____ ***Mobile*** _____ **Email** _____

EMERGENCY CONTACTS

1. **Name** _____ **Relationship** _____
   Phone _____
2. **Name** _____ **Relationship** _____
   Phone _____

PRIMARY PHYSICIAN

Name _____ **Phone** _____
Address _____
City _____ **State** ____ **Zip** _____
Health Insurance Provider _____
Policy Number _____ **Phone** _____
Name of Insured _____

CONSENT

I hereby authorize Infinity Equine Therapy Inc. to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the individual or agency involved in the medical emergency treatment.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the attending physician. I understand that this provision will be invoked if Infinity Equine Therapy, Inc. is unable to reach the emergency contact person(s) listed above.

Signature _____ **Date** _____

In the event that a parent or legal guardian refuses to give consent for emergency medical treatment/aid, said parent or legal guardian must remain on the site at all times with the participant.

INFINITY
EQUINE THERAPY
Post Office Box 92, Closter, New Jersey 07624
http://infinityequine.org

SUPPLEMENTAL MEDICAL FORM

To be completed by participant's primary physician

Participant _____
Address _____
Telephone – Home _____ ***Mobile*** _____ **Email** _____

Diagnosis_____ **Date of Onset** _____
Past/Prospective Surgeries *(describe and provide dates of each)* _____
_____
Current medications/how often administered _____
_____
If participant has experienced seizures, describe type _____
Controlled? Y___ N___ Date of last seizure _____
Shunt Present? Y ___ N___ Date of last revision_____
Special Precautions/Needs *(please list)* _____
_____
Mobility - Independent Ambulation? Y ___ N ____
Assisted Ambulation? Y ___ N ___ **If yes, please describe** _____

For participants with Down Syndrome, please provide the following information:
Atlantoaxial subluxation? Y__ N__ Date of last x-ray _____ **Result + ___ - ___**
(Please Note: Riders with a positive diagnosis for atlantoaxial subluxation may not participate in the riding portion of any IET program)
Neurologic symptoms of atlantoaxial instability _____

Please indicate current or past difficulties in the following systems/areas, including surgeries

	Y	N	Comments
Allergies			
Auditory			

Balance			
Cardiac			
Cognitive			
Circulatory			
Emotional/Psychological			
Immunity			
Integumentary/Skin			
Learning Disability			
Neurologic			
Muscular			
Orthopedic			
Pain			
Pulmonary			
Speech			
Tactile Sensation			
Visual			
Other			

Signature of Physician _____ **Date** _____

Print name _____

Address: _____ Phone: _____

_____

City, State, Zip

Post Office Box 92, Closter, New Jersey 07624
http://infinityequine.org

AGREEMENT OF INDEMNIFICATION, RELEASE AND WAIVER OF LIABILITY

I am the parent/guardian of:_____. In consideration for participating in, or for my child's/ward's participation in, the programs (the "Programs") administered by Infinity Equine Therapy, Inc. (hereinafter, "IET"), I, on behalf of myself and my child/ ward hereby agree as follows:

1. Release and Waiver of Liability. I shall be responsible for all of my or my child's/ward's medical and non-medical expenses resulting from our participation in the Programs and shall not seek reimbursement from IET for such expenses. I forever **RELEASE** and **DISCHARGE** IET, including its trustees, directors, agents, servants, instructors and volunteers (hereinafter, collectively, the "Released Parties") from any and all liabilities, claims, demands or causes of action that I or my child/ ward may now or hereafter have for injuries and damages arising out of my participation, or the participation of my child/ward, in the Programs.

2. Acknowledgement and Assumption of Risk. I understand that the Programs involve horseback riding and other activities involving horses and equipment related thereto. I further understand that there are inherent risks in such activities and that these inherent risks may result in serious injury or death. I understand that these risks exist despite all reasonable precautionary steps taken by the Released Parties. On behalf of myself and my child/ward, I voluntarily assume these risks. I agree to exercise reasonable care and to follow all instructions while participating in the Programs and to ensure that my child/ward exercises reasonable care and follows all such instructions.

3. Indemnification. I hereby agree to indemnify, save and hold harmless any or all of the Released Parties from and against any loss, liability, damage or costs they may incur that arise out of or are in any way connected with either my or my child's/ward's participation in the Programs, to the extent that such loss is caused by or results in any way from my own negligence or the negligence of my child/ward.

I have read this document and understand its contents. I have made a voluntary and knowing decision to sign this document.

Signature _____ Date _____

Print Name _____