PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Participant Registration

Walk On Equine Assisted Activities

Participant Name:_____Today's Date_____

Parents Name, Guardian or Caregiver: _____

Residing Address: _____ City, State, Zip Code: _____

Mailing Address: _____ City, State, Zip Code: _____

Home Number:_____ Cell Phone: _____ Work Phone: _____

E-mail:_____ Alternative E-mail:_____

Date of Birth:_____ Participant's Current Age: _____

Name of School or Occupation: _____ Year in School: _____
(if applicable)

If different than above:

Parents Name, Guardian or Caregiver: _____

Mailing Address: _____ City, State, Zip Code: _____

Home Number:_____ Cell Phone: _____ Work Phone: _____

E-mail:_____ Alternative E-mail:_____

In case of emergency, who may we contact:

Emergency Contact #1: _____

Mailing Address: _____ City, State, Zip Code: _____

Home Number:_____ Cell Phone: _____ Work Phone: _____

E-mail:_____ Relationship to Participant _____

Emergency Contact #2: _____

Mailing Address: _____ City, State, Zip Code: _____

Home Number:_____ Cell Phone: _____ Work Phone: _____

E-mail:_____ Relationship to Participant _____

To be reviewed and updated after 1st year:
Parent/Guardian Signature _____ Date_____

To be reviewed and updated after 2nd year:
Parent/Guardian Signature _____ Date_____

Mailing Address:
P.O. 376
Barrington, IL 60011
WalkOnFarm@comcast.net

Office (847) 381-4231
Barn (847) 842-8349
Fax (847) 381-4288

Barn Address:
26665 West Cuba Rd
Barrington, IL 60010
WalkOnFarm.org

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Walk On
Equine Assisted Activities

Authorization for Emergency Medical Treatment Form

Participant Name: _____

Date of Birth:_____ Home Phone:_____ Cell Phone:_____

City: _____State:_____ Zip Code:_____

Physician's Name: _____Phone:_____

Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to Medication: _____

Current Medications: _____

In the event emergency medical aid/treatment is required due to illness or injury or while being on the property of the agency, I authorize **Walk On** to:

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

Please sign only one below:

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the emergency contact is unable to be reached.

Consent Signature: _____ Date: _____

Participant, ***Parent or Guardian or if under 18 yrs old*** *Signed in presence of staff*

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of riding or while being on the property of the agency.

___ Parent or legal guardian will remain on site al all times during equine assisted activities
___ In the event emergency treatment/aid is required, I wish the following procedure to take place

_____

_____

Non-Consent Signature: _____ Date: _____

Participant, ***Parent or Guardian or if under 18 yrs old*** *Signed in presence of staff*

Mailing Address:
P.O. 376
Barrington, IL 60011
WalkOnFarm@comcast.net

Office (847) 381-4231
Barn (847) 842-8349
Fax (847) 381-4288

Barn Address:
26665 West Cuba Rd
Barrington, IL 60010
WalkOnFarm.org

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Walk On Equine Assisted Activities

Participant Health History

General Information:

Name: _____ Date: _____

Diagnosis:_____

Date of Onset:_____ Age:_____ Medications:_____

Please indicate current or past specials needs in the following areas:

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Cardiac			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/ Mental Health			
Behavior			
Pain			
Bone/Joint			
Muscular			
Cognition/Thinking			
Allergies			

Strengths: _____

Concerns:_____

Goals: _____

I understand that the information provided above is accurate to the best of my knowledge.

Signature: _____ Date: _____

Participant, parent, guardian; signed in presence of center staff

Mailing Address:
P.O. 376
Barrington, IL 60011
WalkOnFarm@comcast.net

Office (847) 381-4231
Barn (847) 842-8349
Fax (847) 381-4288

Barn Address:
26665 West Cuba Rd
Barrington, IL 60010
WalkOnFarm.org

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Participant's Release Form

Walk On Equine Assisted Activities

Participant's General Information

Name: _____ Date: _____

Address:_____

City, State, Zip Code:_____

Photo Release

I _____ Do Consent
_____ Do Not Consent

Social Media (i.e. Facebook)

I _____ Do Consent
_____ Do Not Consent

To and authorize the use and reproduction by **Walk On** of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the center.

Signature: _____ Date_____
Participant, Parent, Guardian

Participant Handbook Checklist

I have read and understand the participant handbook. It is my responsibility to ensure anyone accompanying myself/my son/my daughter/my ward is aware of and follows the rules.

- Cancellation Policy
- Dismissal Policy
- Emergency Procedures
- First Aid Kit Location
- Illinois Equine Liability Act
- Participant Rules

Print Name: _____

Signature: _____ Date_____
Participant, Parent, Guardian

Mailing Address:
P.O. 376
Barrington, IL 60011
WalkOnFarm@comcast.net

Office (847) 381-4231
Barn (847) 842-8349
Fax (847) 381-4288

Barn Address:
26665 West Cuba Rd
Barrington, IL 60010
WalkOnFarm.org

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Walk On Equine Assisted Activities

Participant Liability Release

WARNING

UNDER THE EQUINE ACTIVITIES LIABILITY ACT, EACH PARTICIPANT WHO ENGAGES IN AN EQUINE ACTIVITY EXPRESSLY ASSUMES THE RISK OF ENGAGING IN AND LEGAL RESPONSIBILITY FOR INJURY, LOSS OR DAMAGE TO PERSON OR PROPERTY RESULTING FROM THE RISK OF EQUINE ACTIVITIES 745 ILCS 47/25

I/we _____ would like to participate in the Walk ON program. I/we acknowledge and accept the risks and potential risks of engaging in equine activities, including but not limited to:

1) the propensity of equines to behave in dangerous ways that may result in injury to the participant
2) the inability to predict an equine's reaction to sound, movements, objects, persons, or animals; and
3) the hazards of surface or subsurface conditions.

However, I/we feel the possible benefits to myself/my son/my daughter/my ward are greater than the risks assumed. I/we hereby, intending to be legally bound, for myself, my personal representatives, heirs distributes, guardians legal representatives, next of kin and assigns, waive and release all claims for damages against Walk On, it's owners, lessors, agents, employees, instructors, therapists, volunteers officers, directors, shareholders and members for any and all injuries and losses I/we may sustain while participation in Walk On's program.

Costs and Fees: In the event the undersigned shall commence litigation in respect to their participation in Walk On's program, the undersigned will be responsible for all costs and expenses, including attorney's fees incurred by BOTH parties as a result of such litigation.

Accident/Medical Insurance: I/we the undersigned agree that should emergency medical treatment be required. I/we have or my own accident/medical insurance company shall pay for all such incurred expenses. I have recorded my accident/medical insurance on Walk On's Authorization for Emergency Medical Treatment form.

Severability: In the event that one or more of the provisions of this Agreement are ever invalidated for any reason by a court of competent jurisdiction, any provision so invalidated shall be deemed severable from the other provisions hereof, and the remaining provisions hereof shall continue to be valid and fully enforceable.

I/WE THE PARTICIPANT AND/OR THE PARENT OR GUARDIAN THEREOF IF UNDER 18 YEARS OF AGE OR OTHERWISE CANNOT CONSENT, THE UNDERSIGNED, HAVE READ AND DO UNDERSTAND THE FOREGOING AGREEMENT WARNINGS, RELEASE AND ASSUMPTION OF RISK AND HAVE READ AND VOLUNTARILY SIGN THIS AGREEMENT AND FURTHER AGREE THAT NO ORAL REPRESENTATIONS, STATEMENTS OR INDUCEMENTS APART FROM THE ABOVE WRITTEN AGREEMENT HAVE BEEN MADE BY WALK ON, IT'S OWNERS, LESSORS,AGENTS,EMPLOYEES, THERAPISTS, INSTRUCTORS, VOLUNTEERS, OFFICERS, DIRECTORS, SHAREHOLDERS AND MEMBERS.

I/WE THE PARTICIPANT AND/OR THE PARENT OR GUARDIAN THEREOF IF UNDER 18 YEARS OF AGE OR OTHERWISE CANNOT CONSENT, THE UNDERSIGNED, CERTIFY THAT I HAVE THE LEGAL AUTHORITY TO EXECUTE THIS AGREEMENT. THIS AGREEMENT SHALL REMAIN VALID UNTIL EXPRESSLY REVOKED BY THE PARTICIPANT AND/OR THE PARENT OR GUARDIAN THEROF IF UNDER 18 YEARS OF AGE OR OTHERWISE CANNOT CONSENT.

Consent Signature:_____ Date_____

Participant, Parent or Guardian

Mailing Address:
P.O. 376
Barrington, IL 60011
WalkOnFarm@comcast.net

Office (847) 381-4231
Barn (847) 842-8349
Fax (847) 381-4288

Barn Address:
26665 West Cuba Rd
Barrington, IL 60010
WalkOnFarm.org

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Walk On
Equine Assisted Activities

NON-DISCLOSURE AND CONFIDENTIALITY AGREEMENT

Non-Disclosure and Confidentiality Agreement (the "Agreement") entered into between Walk On, located at 26665 West Cuba Road, Barrington, Illinois 60010, and _____ (the "Participant").

Walk On is an organization that helps children and adults (the "Participants") with a wide range of disabilities including, but not limited to, Spina Bifida, Cerebral Palsy, Down Syndrome, Autism and spinal cord injuries to better use their minds and bodies through equine assisted activities. Volunteers of Walk On assist the Participants with their lessons, work with the horses or assist in the office. Participants expect that their participation in Walk On, the existence and extent of their disabilities, and their experiences with Walk On remain confidential.

Walk On desires to provide to its Participants equine assisted activities on a confidential basis.

Accordingly, Walk On and the Participant agree as follows:

1. The identity of the Participants will not be disclosed by Walk On staff without prior written consent of the Participant or their parents/guardians /representatives;

2. Information concerning the Participants' disabilities will not be disclosed by Walk On staff without prior written consent of the Participants' or their parents/guardians/representatives;

3. The obligations of Walk On under this Agreement shall continue after the Participants cease their association with Walk On unless written consent is given by the Participant or their parents/guardians/representatives;

4. This Agreement shall be governed by and construed in accordance with the laws of the State of Illinois;

5. This Agreement constitutes the complete Agreement between Walk On and the Participant, and this Agreement may not be modified except in writing signed by the parties hereto.

Read, understood and agreed by:

By_____ By_____
Participant, Parent, Guardian *Walk On*

Date_____ Date_____

Mailing Address:
P.O. 376
Barrington, IL 60011
WalkOnFarm@comcast.net

Office (847) 381-4231
Barn (847) 842-8349
Fax (847) 381-4288

Barn Address:
26665 West Cuba Rd
Barrington, IL 60010
WalkOnFarm.org