Participant Registration

Name**:** _____

Parent, Guardian or Caregiver: _____

Address: _____

City, State, Zip Code: _____

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

E-mail: _____ Alternative E-mail: _____

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

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

Parent, Guardian or Caregiver (if different than above) _____

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

Address: _____

City, State, Zip Code: _____

Relationship to Participant: _____

In case of emergency, who may we contact:

Emergency Contact #1: _____

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

Address: _____

City, State, Zip Code: _____

Relationship to Participant: _____

Emergency Contact #2: _____

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

Address: _____

City, State, Zip Code: _____

Relationship to Participant: _____

Mailing Address:
P.O. Box 376
Barrington, IL 60011

Office Phone: (847) 381-4231
Barn Phone: (847) 381-4231
WalkOnFarm@comcast.net

Barn Address:
26665 West Cuba Road
Barrington, IL 60010

Participant - Authorization for Emergency Medical Treatment Form

Participant Name: _____

DOB:_____ Phone:_____

City: _____State:_____ Zip:_____

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*

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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

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Participant Release Form

General Information

Name: _____ Date: _____

Address:_____

City, State, Zipcode:_____

Photo Release

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
Path International

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

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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, its 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.

Date_____

Consent Signature:_____
Participant, Parent or Guardian

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Participant
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_____

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Date: _____

Dear Health Care Provider:

Your patient, _____
Participant's name

is interested in participating in supervised equine activities.

In order to safely provide this service, Walk On requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
AtlantoAxial Instability (include neurologic symptoms)
Coxa Arthosis
Cranial Deficits
Heterotopic Ossification/Myositis
Ossificans Joint Subluxation/Dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromelia

Others
Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self and/or others
Exacerbations of medical conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical
Instability PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse Thought
Control Disorders Weight
Control Disorders

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact Walk On at the address/phone indicated above.

Sincerely,

Mary Illing, OTR/L

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PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Walk On
Equine Assisted Activities

Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____
Address: _____
Diagnosis: _____ Date of Onset: _____
Past/Prospective Surgeries: _____
Medications: _____
Seizure Type: _____ Controlled: Y or N Date of last Seizure: _____
Shunt Present: Y or N Date of last Revision: _____
Special Precautions/Needs: _____
_____Mobility:
Independent Ambulation: Y or N Assisted Ambulation: Y or N Wheelchair: Y or N
Braces/Splints/Orthotics, Assistive Devices: _____
For those with Down Syndrome: AtlantoDens Interval X-Rays, Date: _____ Result: + or --
Neurologic Symptoms or AtlantoAxial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

System/ Area	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that Walk On will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Walk On for ongoing evaluation to determine eligibility for participation.

Name/Title: _____MD DO NP PA Other:_____
Signature: _____Date: _____
Address:_____ Phone:_____
License / UPIN Number: _____

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