Mailing Address for all locations: Agape Headquarters, 24970 Mt. Pleasant Road, Cicero, IN 46034
Fax for all locations: 317-984-9103/ Headquarters phone: 317-773-7433
For more information or to complete an electronic version of this form, please visit our website: WWW.AGAPERIDING.ORG

PARTICIPANT REGISTRATION PACKET FOR:_____
(Name of Participant)

SECTION I. PARTICIPANT INFORMATION

Preferred Agape Location (Select one): ❒ North in Cicero ❒ East in Greenfield

If coming with a group, name of group/organization? _____

Date of Birth: _____/_____/_____ Age: _____

Address: _____ City/State: _____

County: _____ Zip: _____ Ethnicity: _____ Gender:_____

Phone: _____ Email Address: _____

SECTION II. ADULT/GUARDIAN PARTICIPANT INFORMATION IF PARTICIPANT LISTED IN SECTION 1 IS UNDER THE AGE OF EIGHTEEN (18) OR UNDER A LEGAL DISABILITY

Name: _____

Address: _____ City: _____ State: _____ Zip: _____ (If different from participant)

Phone: _____ Email Address: _____ (If different from participant)

Relationship to participant: _____

Please name any caregivers with their phone number and relationship who may transport or be responsible for participant:

_____

_____

Section III. Photo and Media Consent

Agape Therapeutic Riding Resources, Inc. requests that the above-listed Agape Equine Participant consent to and authorize the use and reproduction by Agape Therapeutic Riding Resources, Inc. of any and all photographs and any other audio-visual materials taken of the above-listed Agape Equine Participant for publication in promotion material, educational activities, exhibitions, publications, broadcasts, website and any other use which promotes Agape Therapeutic Riding Resources, Inc. and its programs.

Please check only one: ____ I do consent. ____ I do **not** consent.

_____ Date: _____
SIGNATURE of Participant or Parent/Guardian

Section IV. Emergency Contact Information

Name: _____ Relationship to Participant: _____
(Primary Contact)

Telephone Numbers: _____

Name: _____ Relationship to Participant: _____
(Secondary Contact)

Telephone Number(s): _____

Preferred Medical Facility: _____

Information for Emergency Medical Providers: _____
(Such as allergies, medications, pre existing medical conditions)

Agape Emergency Medical Policy

In the event emergency medical aid/treatment is required for a Participant, Agape Therapeutic Riding Resources, Inc. will:

1. Contact 911, state the nature of the emergency and request that an ambulance be sent to the scene of the occurrence;
2. Contact the person(s) listed above in the priority listed; and
3. Provide the information listed above to emergency medical providers.

I have read and acknowledged the Agape Emergency Medical Policy.

_____ Date: _____
SIGNATURE of Participant or Parent/Guardian

SECTION V. LIABILITY

EQUINE ACTIVITY RELEASE, ASSUMPTION OF RISK AND AGREEMENT TO INDEMNIFY

This *Equine Activity Release, Assumption of Risk and Agreement to Indemnify* (the "Agreement") is hereby entered by on the dates indicated below.

A. Scope of Services Provided. Agape Therapeutic Riding Resources, Inc. ("Agape") is a not-for-profit organization that sponsors, organizes and/or provides facilities for activities involving equines including, but not limited to, therapeutic riding and equine-facilitated learning programs with such activities taking place both on the premises owned by Agape ("Premises") and at other locations within the State of Indiana ("Locations") (collectively "Agape Equine Activities").

B. Inherent Risks of Equine Activities. The undersigned expressly understands that certain dangers or conditions are an integral part of such Agape Equine Activities including but not limited to: i) The propensity of an equine to behave in ways that may result in injury, harm, or death to persons on or around the equine, ii) The unpredictability of an equine's reaction to such things as sound, sudden movement, unfamiliar objects, people, or other animals, iii) Hazards such as surface and subsurface conditions, iv) Collisions with other equines or objects and v) The potential of a person involved in Agape Equine Activities to act in a negligent manner that may contribute to injury to that person and/or other persons, such as by failing to maintain control over an equine. **The undersigned expressly understands and agrees that such dangers or conditions exist whether a person is: i) personally engaging in Agape Equine Activities, ii) a spectator of Agape Equine Activities or iii) entering, departing or being on the Premises or Locations where Agape Equine Activities are taking place and that by doing any of these actions, such a person is a "Participant."**

C. Assumption of Risk, Release and Waiver of Liability and Indemnity Agreement. In consideration of Agape allowing the undersigned, as well as those persons for whom the undersigned has listed herein, to be a Participant and with an understanding of the Inherent Risks of Equine Activities as set forth in Paragraph B above, the undersigned, individually and on behalf of each persons listed herein by the undersigned, hereby assumes all such risks and forever releases, waives, discharges and covenants not to sue Agape Therapeutic Riding Resources, Inc. (including its directors, officers, shareholders, employees, agents, representatives, volunteers, insurers, affiliates, successors, assigns and others acting on Agape Therapeutic Riding Resources, Inc.'s behalf including, without limitation, independent contractors such as trainers, instructors, veterinary personnel, farriers, equine care providers and maintenance personnel) (collectively the "Released Parties") from all liability, loss, claims, demands, possible causes of action, court costs, attorneys' fees and other expenses, known or unknown, anticipated or unanticipated, that may result from any loss, damage or injury (including death) to the person or property of i) the undersigned and ii) each person listed herein by the undersigned which, in any way, results from, or arises in connection with, or relates to, any Agape Equine Activity whether caused by the negligence of the Released Parties or others. I acknowledge the contagious nature of COVID-19, and other respiratory viruses, and voluntarily assume the risk of being exposed to or infected by COVID-19 or other respiratory infections while on Agape property and I hereby fully release Agape, its agents and assigns, from any and all damages, liability, costs and expenses related to any such exposures or infections.

D. The undersigned further hereby agree to indemnify and hold harmless the Released Parties and each of them from any and all loss, liability, damage or cost they may incur due to the undersigned and each person listed herein by the undersigned being a Participant whether caused by the negligence of the Released Parties or otherwise.

The undersigned agrees that the Indemnification Agreement shall also apply as to any loss, liability, damage or cost incurred by persons and their property who have not executed an *Equine Activity Release, Assumption of All Risk and Agreement to Indemnify* but who the undersigned invited or otherwise encouraged to be a Participant.

D. <u>Binding Effect</u>. This Agreement shall be binding upon the heirs, executors, administrators, agents, insurers and assigns of the undersigned and shall inure to the benefit of and may be enforced by the Released Parties. **If this Agreement is executed for and on behalf of a Participant who is under the age of eighteen (18) or under some other legal disability, the undersigned hereby represents and warrants that he or she is in fact the legal parent or guardian of said Participant with full rights of custody and control and that this Agreement and all terms contained herein is given on behalf of and is intended to be binding upon said Participant, his/her heirs, executors, administrators, agents, insurers and assigns.**

E. <u>Complete Agreement, Choice of Law, Venue and Attorneys Fees</u>. The terms of this Agreement contain the entire agreement of the parties as to the subject matter set forth herein and shall be governed by the laws of the State of Indiana. In the event any provision of this Agreement is deemed to be invalid or unenforceable by any court or administrative agency of competent jurisdiction, then the Agreement shall be deemed to be restricted in scope or otherwise modified to the extent necessary to render its provisions valid and enforceable. The parties agree that Hamilton County, Indiana is the exclusive venue for any legal proceedings arising from or related to this Agreement and the Released Parties shall be entitled to recover the costs incurred (including reasonable attorney's fees) from the undersigned in the event that any legal action (regardless of whether a lawsuit is filed) is required to enforce this Agreement.

I HAVE FULLY READ AND FULLY UNDERSTAND THIS EQUINE ACTIVITY RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF ALL RISK AND AGREEMENT TO INDEMNIFY. I UNDERSTAND THAT, BY SIGNING THIS DOCUMENT, I MAY BE WAIVING AND RELEASING CERTAIN IMPORTANT RIGHTS WHICH I MIGHT HAVE IF I DID NOT SIGN THIS AGREEMENT. I AM SIGNING THIS DOCUMENT VOLUNTARILY AND WITHOUT ANY COERCION.

<u>ADULT/GUARDIAN(S) FULL NAME</u> EACH PARTICIPANT UNDER THE AGE OF 18 OR UNDER A LEGAL DISABILITY FOR WHOM EACH ADULT IS SIGNING:

_____
SIGNATURE and Date

_____
Printed Name

_____
SIGNATURE and Date

_____
Printed Name

_____
Participant Name

_____
Participant Name

WARNING

UNDER INDIANA 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.

SECTION VI. HEALTH HISTORY

PARTICIPANT INFORMATION

Participant Name: _____

Diagnosis/Disability (Required): _____ Date of Onset (if applicable): _____ Height (Required for riding): _____ Weight (Required for riding) : _____

DIAGNOSIS & CONDITIONS

If the answer to any of the following health questions is 'yes", a Physician's Release form (p.7) is required.

Yes	Condition	Date	Details
	Down Syndrome		
	Spinal condition (i.e. injury, scoliosis, fusion, Spina Bifida)		
	Brain condition (i.e. Cerebral Palsy, stroke)		
	Bleeding or clotting disorders		
	Diabetes		
	Fatigue & Immune Deficiency		
	Joint & bones complications (i.e. hip dysplasia, arthritis)		
	Epilepsy/Seizures and the Type(s) experienced		
	Muscular		
	Heart Condition		
	Neurological Condition		
	Pulmonary Condition		
	Skin Breakdown or Pressure Sores		

In the past 12 months, has the participant been treated for any of the following? If yes, check the box, provide date of occurrence and details:

Yes	Condition	Date	Details
	Hospitalization for any serious injury, condition, surgery		
	Experienced loss of consciousness including seizures?		
	Experienced a psychotic crisis?		

	Need assistance to maintain an upright position or control his/her head?		
	Been necessary to restrict activities due to medical reasons?		
	Does the participant use crutches, walker, or wheelchair?		
	Does participant have a G-tube?		
	Does participant have a catheter?		
	Does participant have a shunt?		

GENERAL HEALTH AND FUNCTION
Please describe any conditions or issues in the following areas:

	Details
Hearing	
Vision	
Speech	
Circulation	
Cognitive Development	
Emotional or psychological	
Behavior	
Allergies *If the participant uses an Epi-Pen, please describe when it is needed.	
Please describe any incidents of Asthma and causes of asthma. *If the participant uses an inhaler for any reason, please describe when it is needed.	

Medications_____

Medical devices used _____ Tetanus

Shot: No Yes Date of Shot_____

SIGNATURE: I hereby affirm that, to the best of my knowledge, the health history information is complete and correct.

Name of person completing this form: _____Date:_____

SIGNATURE: _____Relationship to Participant: _____

Physician's Release Form For Agape

Please return this form by mail/fax to Agape Headquarters:
Mailing Address for all locations: Agape Headquarters, 24970 Mt. Pleasant Road, Cicero, IN 46034
Fax for all locations: ***317-984-9103*** *Headquarters phone:* ***317-773-7433***

This form is **required** if: ❒ Participant has Down Syndrome OR; ❒ If one or more of the health questions of the Health History Form are 'Yes'.

Participant Name: _____ DOB: _____ Weight (required): _____ Name of

Parent(s)/Guardian(s):_____

Diagnosis: _____ Date(s) of onset: _____

Special Precautions: _____

Seizure Type: _____ Controlled: **Y N** Date of last Seizure:_____

For those with **Down Syndrome** - Upon annual examination by physician, Neurologic Symptoms of Atlantoaxial Instability (AAI) are: _____ **PRESENT** or _____ **ABSENT** *Participant cannot ride if AAI Positive

Date of physical exam (must be within 1 calendar year)_____Physician Initials: _____

Before anyone with Down Syndrome can ride, *Agape must be provided with a record that a X-ray has been performed and the X-ray* does not show evidence of being AAI positive. An X-ray does not need to be performed annually, only upon initial participation in mounted services. Consecutives thereafter just need to be examined by a physician to check for neurologic symptoms of AAI.

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	Check if a concern	Comments, if there is a concern.
Auditory		
Visual		
Tactile Sensation		
Speech		
Cardiac		
Circulatory		
Integumentary/Skin		
Immunity		
Neurologic		
Pulmonary		
Muscular		
Balance		
Orthopedic		
Allergies		
Cognitive		
Emotional/Psychological		
Pain		
Other (Explain)		

Jarring Toleration:

□ YES □ NO For activities at the horse barn such as horseback riding, can the participant tolerate jarring? If *no, participant will not be allowed to ride*, please explain limitations/recommendations:_____

PHYSICIAN'S RELEASE

I have examined the above-named participant and, given the participant's diagnosis and health history, this person does not present apparent clinical contraindications for equine sports. I understand that Agape will weigh the medical information provided against the existing precautions and contraindications; therefore, I refer this person to Agape for ongoing evaluation to determine eligibility for participation.

PHYSICIAN'S SIGNATURE: _____ **Date:**_____

Physician's Name (please print):

Phone:

Address/City/Zip: