



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 South in Martinsville East in Greenfield

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

Address: _____ City/State: _____

County: _____ Zip: _____ Ethnicity: _____ Gender: M/F

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Preferred method of communication: Mobile Phone Home Phone Email Other: _____

Place of Employment: _____

Are you presently a student? Yes/No If yes, name of school: _____

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: _____ Father/Mother/Guardian

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____
(If different from participant)

Place of Employment: _____ Email Address: _____

Please name any caregivers/phone numbers 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): _____

Primary Physician Name/Telephone Number(s): _____

Preferred Medical Facility: _____

Health Insurance Provider: _____ Policy/Identification Number: _____

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 acknowledge the Agape Emergency Medical Policy.

Date: _____

SIGNATURE of Participant or Parent/Guardian

**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. Binding Effect. 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. Complete Agreement, Choice of Law, Venue and Attorneys Fees. 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	_____ Participant Name
_____ Printed Name	_____ Participant Name
_____ SIGNATURE and Date	_____ Participant Name
_____ Printed 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: _____ Weight: _____

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		
	Muscular		
	Heart condition		
	Neurological condition		
	Pulmonary condition		
	Skin break down 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 or surgery?		
	Experienced loss of consciousness, including seizures?		
	Experienced a psychotic crisis?		
	Need assistance to maintain an upright sitting position or control of his/her head?		
	Been necessary to restrict activities due to medical reasons?		
	Does the participant have crutches?		
	Does the participant have a walker?		
	Does the participant have a wheelchair?		

	Does the participant have a G-tube?		
	Does the participant have a catheter?		
	Does the 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	
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.	
Other	

Please list if applicable:

Medications _____

Medical devices (feeding tubes, shunts, etc.) _____

Allergies _____

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: _____

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Headquarters phone: 317-773-7433

To submit this form electronically, please visit our website: <https://agaperiding.org/adaptive-services-intake-form/>

Please return this form by mail/fax to: Agape Headquarters:
24970 Mt. Pleasant Road, Cicero, IN 46034; Fax (317) 984-9103

PHYSICIAN'S RELEASE FORM FOR AGAPE

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 INFORMATION

Participant Name: _____ DOB: _____ Participant Weight: _____

Name of Parent(s)/Guardian(s): _____ Phone: _____

PHYSICIAN'S REPORT

Medical	Normal	If not normal, please explain
Appearance and affect		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Pulses		
Heart		
Lungs		
Abdomen		
Skin		
Neurologic		
Musculoskeletal		
Neck		
Back		
Upper Extremities		
Lower Extremities		

REQUIRED FOR PERSONS WITH DOWN SYNDROME

Annual physical examination should reveal no symptoms of AAI.

X-ray NOT REQUIRED or accepted in place of annual physical exam

*****NO INDIVIDUAL MAY RIDE WITH POSITIVE SYMPTOMS OF AAI*****

Annual physical examination for AAI: Negative _____

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

Doctor's Initials _____

Jarring Toleration:

YES NO For activities at the horse barn such as horseback riding, can the participant tolerate jarring?

If no, please explain limitations in detail:

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:

Physician's Name (please print):
Address/City/Zip:

Date:
Phone: