



Renew Therapeutic Riding Center
4271 60TH Street, Holland, MI 49423

PARTICIPANT APPLICATION, HEALTH HISTORY & RELEASE INFORMATION

GENERAL INFORMATION

Participant Name: _____ Date: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Male () Female ()

Address: _____

Phone: (H) _____ (W) _____ (C) _____

Email address: _____

Employer/School: _____

Address: _____

Parent/Legal Guardian/Caregiver: _____

Address (if different from above): _____

Phone (if different from above): _____

How did you hear about our program? _____

HEALTH HISTORY

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

Signature: _____ **Date:** _____

Participant (if 18 or older), Parent or Legal Guardian

What medications are you/your student currently taking, including over-the-counter medications?

Describe your/your students' abilities/difficulties in the following areas (including assistance required or equipment needed):

Function: Mobility skills such as transfers, walking, wheelchair use, driving/bus riding.

Social: Work/school activities, including grade completed, leisure interests, relationships, family structure, support systems, companion animals, fears/concerns, etc.

Goals: Why are you applying for participation? What would you like to accomplish?

MEDIA RELEASE

I DO
 DO NOT

consent to and authorize the use and reproduction by *Renew Therapeutic Riding Center* of any and all photograph, any other audio/visual materials taken of me and/or my child, and any artwork produced by me and/or my child or other family members for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

Signature: _____ **Date:** _____
Participant (if 18 or older), Parent or Legal Guardian

IN THE EVENT OF EMERGENCY, PLEASE CALL:

Contact name: _____ Phone #: (_____) _____
Contact name: _____ Phone #: (_____) _____

LIABILITY RELEASE

Michigan State Equine Laws state that: Under Michigan 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. _____ (participant’s name) would like to participate in the Renew Therapeutic Riding Program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/my son/ my daughter/my ward are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims to damages against Renew Therapeutic Riding Center Inc, it Board of Directors, Instructors, Volunteers, Employees, Stable Owners, and/or Stable Employees, as well as for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating at Renew Therapeutic Riding Center.

Signature: _____ **Date:** _____
Participant (if 18 or older), Parent or Legal Guardian

CONFIDENTIALITY AGREEMENT

I understand that all information about any and all participants at Renew Therapeutic Riding Center is to remain confidential and I agree to uphold the center’s Confidentiality Agreement in accordance with PATH International standards.

Signature: _____ **Date:** _____
Participant (if 18 or older), Parent or Legal Guardian

ELIBIBILITY AND DISCHARGE REQUIREMENTS

I understand that for safety reasons, there are Eligibility Requirements for participation in activities and programs offered by Renew Therapeutic Riding Center based upon the recommendations by PATH International’s list of Precautions and Contraindications as well as the safe weight limit and health of the program horses. I also understand that these Eligibility Requirements are for reasons of safety for all involved in the program, including the participants, volunteers, staff, and horses. If it becomes unsafe or inappropriate for me/my child to participate according to any of these policies, then I understand that I will be discharged from the program and no longer eligible to participate until the time that the Eligibility Requirements are met.

Signature: _____ **Date:** _____
Participant (if 18 or older), Parent or Legal Guardian