PARTICIPANT INFORMATION FORM
Required for participation

Name:_____ DOB:_____

It is helpful for the staff at High Hopes to know your goals, interests, and understand your current status prior to developing a program for you. Please complete the following questions.

Primary Disability or diagnosis: _____
Secondary Disability or diagnosis: _____
Tertiary Disability or diagnosis: _____

Other medical considerations (i.e., allergies, health precautions, medications, etc.): _____
_____

School/Program presently attending and teacher/counselors name (if applicable): _____
Program or staff email/phone no. _____

If participant is not their own contact:
Primary Contact Name (for scheduling and mailings): _____ Relationship: _____
Mailing Address: Street: _____City: _____
County: _____ State: ____ Zip:_____
Home Ph: _____Cell Ph: _____E-Mail: _____

Billing Contact Name (if not same as above): _____ Relationship: _____
Mailing Address: Street: _____City: _____
County: _____ State: ____ Zip:_____
Home Ph: _____Cell Ph: _____E-Mail: _____

Additional Emergency Contact Information (list primary emergency contact on Registration & Release):
Emergency Contact 2:_____ Relationship: _____
Home Ph: _____ Work Ph: _____ (ext) ___Cell Ph: _____

Please indicate the program(s) you are interested in:
☐ Riding ☐ Carriage Driving ☐ Equine Learning (unmounted) ☐ Summer Camp ☐ Veterans Program ☐ Other_____

Availability: Day(s):_____ Times: _____

Posture: _____

Balance: _____

Movement/Coordination:_____

General attitude & behavior: _____

Communication methods (Verbal, Sign, PEC): _____

Cognitive abilities (age level, multi-step directions): _____

What are your goals (i.e., riding/driving skills, behavioral changes, physical improvements, paying attention)? Please be specific:

_____

Describe any previous horse experience: _____

Areas of interest & activities enjoyed: _____

Please note that High Hopes Therapeutic Riding, Inc. may require additional proof of medical clearance from a health care provider if deemed necessary.

Signature: _____ Date: _____
Participant/Parent/Legal Guardian

HIGH HOPES THERAPEUTIC RIDING INC
REGISTRATION & RELEASE
PLEASE COMPLETE ENTIRE FORM

☐ **Volunteer** ☐ **Participant** ☐ **Community Lessons** ☐ **Veteran's Program** ☐ **Summer Camp** ☐ **Horse Sense** ☐ **Immersion**

☐ **Visitor** ☐ **One Day Vol/Group** ☐ **Training & Edu.** ☐ **Field Trip or Birthday Party** ☐ **Other**

Name: _____ Home #:_____ Cell #:_____DOB: _____

Address: _____ Town: _____

State: _____ Zip: _____ County: _____ Email: _____

Gender: _____ **Height:** _____ **Weight:** _____ *(Height & weight used in horse & volunteer assignments.)*

Ethnicity: ☐ White ☐ Hispanic, Latino, or Spanish ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native
☐ Middle Eastern or North African ☐ Native Hawaiian or Other Pacific Islander ☐ Other race or ethnicity ☐ Prefer not to answer

In case of emergency, contact: (Parent if minor) _____ Phone: _____
Please indicate any medical conditions or medications we should be aware of in the event of an emergency: _____
_____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT: In the event emergency medical aid/treatment is required due to illness or injury while being on the property of the agency, I authorize High Hopes to secure and retain medical treatment and transportation, if needed, and release records upon request to the authorized individual or agency involved in emergency medical treatment.

Date: _____ Consent Signature: _____
If applicant is under 18 years of age, parent/guardian signature is required.

*If you choose non-consent for emergency medical treatment/aid in the event of illness or injury while on the property of the agency, please request a Non-Consent Form, which requires notarization.

PHOTO VIDEO & PUBLICITY RELEASE: By engaging in activities at High Hopes Therapeutic Riding, Inc. I understand that I/my child/my ward may be photographed, filmed, or videotaped and I hereby give High Hopes Therapeutic Riding, Inc. the unqualified right to take pictures and/or recordings of me/my child/my ward and grant the perpetual right to use that likeness, video, image, photograph (collectively "image"), without compensation, for broadcast or exhibition in any medium and to put the finished images/recordings to any legitimate use without limitation or reservation. I hereby waive, release and forever discharge High Hopes Therapeutic Riding, Inc. from and against any and all claims or actions arising out of, or resulting from any use of such image. High Hopes Therapeutic Riding, Inc. shall not be obligated to use, and may elect not to use, any image.

☐ **Consent** ☐ **Do Not Consent**

Date: _____ Signature: _____
If applicant is under 18 years of age, parent/guardian signature is required.

CONFIDENTIALITY POLICY: At High Hopes, we place great importance on protecting the confidential information of our clients, our staff and our volunteers. "Confidential information" includes, but is not limited to, personally identifiable information such as surnames, telephone numbers, addresses, e-mails, etc. as well as the non-public business records of High Hopes. In particular, medical information about clients and information about their disabilities or special needs must be protected as confidential information. I shall never disclose confidential information to anyone other than High Hopes staff. I must seek staff permission before taking any pictures or videos. I have read and understand the High Hopes Confidentiality Policy and agree to abide by same.

Date: _____ Signature: _____
If applicant is under 18 years of age, parent/guardian signature is required.

LIABILITY RELEASE: I acknowledge the risks and potential for risks of horseback riding and related equine activities including grievous bodily harm. However, I feel that the possible benefits to myself 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 for damages against High Hopes Therapeutic Riding Inc., its Board of Trustees, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I may sustain while participating in activities at High Hopes from whatever cause, including but not limited to the negligence of these related parties.

The undersigned acknowledges that he/she has read this registration form in its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.

Date: _____ Signature: _____
If applicant is under 18 years of age, parent/guardian signature is required.