FIELDSTONE FARM

16497 Snyder Road
Chagrin Falls, OH 44023
440.708.0013
Fax: 440.708.0029
programs@fieldstonefarm.org

2024 REGISTRATION

Participant:_____Date of Birth:_____Age: _____

Street: _____

City:_____County:_____Zip Code: _____

Primary Phone:_____cell or home ***(circle one)***

For adult participants: Secondary Phone:_____cell, home or work ***(circle one)***

Primary Email for Billing and Communication: _____

School or Institution presently attending: _____

Participant is a ***(circle one)***: Minor Adult w/a legal guardian Independent adult

For new students: How did you hear about us?_____

For grant writing purposes only, please indicate participant's ethnic background. Check any that apply:

Caucasian☐ Asian☐ Hispanic/Latino☐ African American☐ Native American☐ Other☐

Is the participant a veteran or active military of the U.S. Armed Forces? **(Circle one):** Yes No

Branch of service: _____

For minors or adults with legal guardians (Required):

Parent or Guardian Name:_____Occupation: _____

Employer:_____Work Phone: _____

Cell Phone:_____Email: _____

Address if different than participant:_____Relationship to participant:_____

Other Parent or Guardian Name:_____Occupation: _____

Employer:_____Work Phone: _____

Cell Phone:_____Email: _____

Address if different than participant or first guardian:_____

Relationship to participant:_____

Please name any caregivers/phone numbers who may transport or be responsible for Participant:

_____

Participant Name:_____**Date of Birth:** _____

IN CASE OF EMERGENCY

In the event of a medical emergency, Fieldstone Farm will provide basic first aid and/or call 911 and will disclose all available health care information to emergency medical personnel.

Please list **two** Emergency Contact names/phones:

Emergency Contact Name:_____Phone: _____

Emergency Contact Name:_____Phone: _____

Please note any LIFE THREATENING allergies (bees, asthma, medications):

_____

_____

_____

PHOTO RELEASE

For valuable consideration, the receipt of which from Fieldstone Farm Therapeutic Riding Center and PATH Intl. is hereby acknowledged, the undersigned hereby grants to Fieldstone Farm permission to take, or have taken, still and moving photographs, videos and films including television pictures of myself and/or the participant for use by Fieldstone Farm, its advertising agencies, news media, and any other persons involved with Fieldstone Farm and its programs including PATH Intl., to use and reproduce the photographs, films, videos and pictures and to circulate and publicize the same by any means deemed appropriate by Fieldstone Farm, including without limitation newspapers, television media, online media, brochures, pamphlets, magazines, instructional materials, books and clinical materials.

No inducements or promises have been made to me to secure my signature to this release other than the intention of Fieldstone Farm to use or cause to be used such photographs, films, videos and pictures for the primary purpose of promoting and aiding Fieldstone Farm and/or PATH Intl. and its programs.

___I DO consent ___I DO NOT consent

Date:_____ Signature: _____

RELEASE AND HOLD HARMLESS AGREEMENT

The undersigned agrees on behalf of himself/herself, the undersigned's minor child and/or the undersigned's representatives, heirs and assigns ("Releasing Parties") to the following:

A. Fieldstone Farm Therapeutic Riding Center ("Fieldstone Farm") has fully explained to him/her the risks involved with horseback riding, carriage driving, showing horses, horse-related activities and/or being in close proximity of horses. These risks include but are not limited to: 1. the propensity of a horse to behave in ways that may result in bodily injury; physical harm, permanent disability; death, or loss to persons around the horses, including without limitation, the rider, driver, handler; and spectator; 2. the unpredictability of horse's reaction to sound, sudden movement, unfamiliar objects, persons, or other animals, which reaction may include but is not limited to changing speed or direction at will, shifting its weight, bucking, rearing, kicking, biting, running from danger, stepping on a person's feet, pushing or shoving a person; 3. hazards, including but not limited to surface and subsurface conditions, 4. collision with another horse, animal, person or object; and 5.the potential of the Releasing Parties, or any other person involved in an equine activity to act in a negligent manner that may contribute to injury, death permanent disability, or loss to any of the Releasing Parties or the other persons, including, but not limited to failing to maintain control over a horse or failing to act within the ability of the participant. The Releasing Parties each further understands that the horse is a prey animal and regardless of its calm nature and training, the horse may revert to its natural instinct to fight or flee when frightened, which may result in injury, death, permanent disability, or loss to you or other persons. By signing this Release, the Releasing Parties each assumes all of the dangers and risks associated with horse activities and being in close proximity of horses, including those risks enumerated above.

B. In consideration of the privilege of riding, handling, and working around and being in close proximity to horses at Fieldstone Farm located at 16497 Snyder Rd., Chagrin Falls, Ohio, the Releasing Parties each releases, discharges and promises not to sue Fieldstone Farm, or any of it employees, officers, directors, trustees, members, volunteers, successors and assigns for any loss, damage, injury, including death or cost to any of the Releasing Parties or persons accompanying any of the Releasing Parties arising out of riding, handling or being in close proximity of horses and equine activities, including without limitation failing to wear a protective helmet and or use of saddles, bridles, helmets, equipment and gear provided by Fieldstone Farm or any other person or entity. The Releasing Parties also each agrees to discharge, release and promises not to sue Fieldstone Farm from any claim arising from Fieldstone Farm's training or selecting of the horses, maintenance, care, fit or adjustment of saddles or bridles, instruction on riding and related skills or leading or supervising Releasing Parties in his/her riding and other equine activities, including without limitation non-riding activities such as handling, bathing and grooming horses.

C. The Releasing Parties each agrees to indemnify and hold harmless Fieldstone Farm, its employees, volunteers, trustees, directors, officers, successors, assigns and students from and against any loss, liability, damage, expense or costs including attorney fees that it may incur or incurs arising out of or in any way connected with the Releasing Parties' participation in equestrian activities, including without limitation, handling or riding of horses or being in close proximity to a horse or due to the failure to wear a helmet when riding or handling and/ or use of saddles, bridles, equipment in connection with the equestrian activities. This indemnification provision shall survive the signing of this Release.

D. The Equine Liability Law, Ohio Revised Code Section 2305.321 generally states in part: *Equine (Horse) Activity Sponsor is not liable in damages in tort or other civil action or harm that and Equine Participant allegedly sustains during an equine activity and that results from inherent risk of equine activity.*

_____

Signature Date

_____

Print Name

_____

Name of minor child (if applicable)

HEALTH HISTORY

Participant's name: _____ Date of Birth: _____

Height (Required): _____ **Weight (Required):** _____

Gender (Circle one, Required): Woman/Girl Man/Boy Transgender Nonbinary/Nonconforming Other Prefer Not to Share

Fieldstone Farm often applies for grants based on characteristics of the students and families we serve. We may have an opportunity to apply for a grant focused on serving individuals who have been diagnosed with cancer or who have a family member who has been diagnosed with cancer. If you are comfortable sharing, have you or anyone in your family received a cancer diagnosis? **(Circle one)** Yes No

List ALL Diagnoses or Disabilities (Required): _____**Date of Onset (year):** _____

If the answer to any of the following HEALTH QUESTIONS is YES, a Physician's Release form (p.7) is required.

Has the participant ever been treated for any of the following? **If yes, check the box**, provide date of occurrence and details:

Yes		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		
	Joint complications such as hip dysplasia		
	Epilepsy		Date of most recent seizure:
	Heart condition including pacemakers		
	Neurological condition i.e. hydrocephalous, mitochondrial disorder		
	Pulmonary condition		
	Skin break down or pressure sores		
	Medical shunt or any type of feeding tube		

In the past 12 months, has the participant experienced:

1. Loss of consciousness, including seizures: Yes
2. Any seizure activity for any reason Yes
3. Hospitalization for a mental health crisis: Yes
4. Hospitalization for any serious injury, condition or surgery Yes
5. Activity restrictions due to medical reasons: Yes
6. The need for assistance to maintain an upright sitting position or control of the head: Yes
7. A medical device such as an insulin pump, catheter, or colostomy bag: Yes

If ***Yes*** to any of the questions above please provide date and details: _____

And complete a required Physician's Release (pg. 7)

GENERAL HEALTH AND FUNCTION

Has the participant ever been treated for the following? If yes, please provide details:

	Yes	Details
Hearing		
Vision		
Speech		
Immune deficiency		
Circulation		
Cognitive Development		
Pulmonary		
Fatigue or limited endurance		
Muscular		
Orthopedic (incl. spine & joints)		
Emotional or Psychological		
Behavior		
Broken bones		
Other		

Medications: _____

Allergies: _____

Does the participant have or use:

Asthma	Yes
EpiPen	Yes
Inhaler	Yes

Walker	Yes	
Crutches	Yes	
Wheelchair	Yes	
Body brace of any type	Yes	Describe

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: _____

IMPORTANT: Fieldstone Farm reserves the right to request additional information and/or an evaluation by the participant's licensed medical professional prior to or during the course of equine-assisted programming and/or to restrict or offer alternative activities until such information or evaluation is procured.

Fieldstone Farm Student Goal Checklist

Student name: _____

Age: _____ Date: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Form completed by: _____

Our instructors would like to know the important life goal that the rider/participant/you is working towards. This information helps us to structure our lesson plans. Examples are: walking without assistance, independent living, decision making, etc.

1. What is a major life goal? _____

   _____

2. Please rank the **goals in each category -** physical goals, social goals, and cognitive goals - as you feel they are important to you/your student. **Rank them 1 through 3** with 1 being the most important.

Physical Goals		Social Goals		Cognitive Goals	
	Balance • Posture		**Socialization** • Enjoyment • Participation • Sportsmanship		**Readiness skills** • Verbal skills/Vocalizations • Vocabulary Expansion • Word Recognition/ Reading skills • Math Skills • Shape recognition • Color Identification
	Coordination • Fine Motor Skills • Range of Motion • Spatial Awareness		**Confidence** • Self-esteem • Responsibility • Independence		**Decision making** • Sequencing
	Strength • Head Control • Gross Motor Skill • Muscle tone (increase) • Muscle tone (decrease)		**Communication** • Cooperation • Transition between activities		**Concentration** • Focus • Attention (increase) • Attention (decrease)

Other: _____ Other:_____ Other: _____

If needed, what behavior modification techniques would you suggest or recommend instructors use in the barn and during lesson if the participant is experiencing a challenge?

_____

_____

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PHYSICIAN'S RELEASE

This form is required if:

- ❒ Participant has **Down syndrome or seizure activity**
- ❒ If one or more of the HEALTH QUESTIONS on page 4 are answered YES

Participant Name:_____ Date of Birth: _____

Parent/Guardian Name:_____ Phone: _____

PHYSICIAN'S REPORT **MEDICAL** (if not within normal ranges,
Appearance and Affect
Eyes/Ears/Nose/Throat
Lymph Nodes
Pulses
Heart
Lungs
Abdomen
Skin
Neurologic
MUSCULOSKELETAL
Neck
Back
Upper Extremities
Lower Extremities
FOR PERSONS WITH DOWN SYNDROME
Does this patient have symptoms consistent with atlantoaxial instability? Yes No DATE OF EXAM: _____
FOR PERSONS WITH SEIZURE ACTIVITY
Does this patient still require close supervision due to seizure symptoms? Yes No

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 Fieldstone Farm will weigh the medical information provided against the existing precautions and contraindications; therefore, I refer this person to Fieldstone Farm for ongoing evaluation to determine eligibility for participation.

Physician's Signature:_____ Date: _____

Physician's Name (**please print**):_____ Phone: _____

Address/City/Zip: _____

SEIZURE EVALUATION FORM

Complete the following form if the participant has experienced seizure activity within the past 3 years. Seizure paperwork must be completed every 6 months for all participants who have had a seizure or seizure activity in the calendar year. If the participant has been seizure-free for more than 3 years, Fieldstone Farm will not follow our active seizure-related procedures such as providing a volunteer spotter during mounted lessons.

Instructions: Please complete this form including as much information as possible. Since working around horses is a risk activity, conditions that increase that risk are carefully analyzed. The safety of all participants, volunteers and horses is considered.

Student's Name _____

Parent/Guardian Name _____

Parent/Guardian Preferred Phone _____

You are encouraged to consult with the physician who manages your or your child's seizure care when completing the following:

Type of Seizure (if more than one, please list all types) _____

_____

Are you/Is your child under the care and treatment of a seizure physician (e.g a neurologist)?

- ☐ Yes
- ☐ No

Are you/Is your child taking medication to control the seizures?

- ☐ Yes
- ☐ No

Date of Last Seizure _____Frequency of seizures _____

Duration of Average Seizure _____

Typical Causes of Seizure Activity _____

_____

Seizure activity indicators: (aura, behaviors or manifestations of oncoming seizure activity) _____

_____

Are you / is your child able to know when a seizure may occur? Can you / they express it? What are the signs?

_____

_____

During a seizure, I / my child:

□ May stare briefly (How long? _____)
□ May walk around
□ May perform aimless activities
□ May suddenly cry / fall / become rigid, followed by muscle jerks / saliva on lips / bluish skin color
□ May experience loss of bladder or bowel control
□ May be confused, have a headache, be fatigued; followed by full return of consciousness
□ Other. Please explain:

After Affect _____

_____

Current Medications _____

_____

Please note most recent seizure activity and incidents with comments (add additional rows as necessary)

Date/time	Details	Care provided
Date/time	Details	Care provided
Date/time	Details	Care provided
Date/time	Details	Care provided

Should you / your child experience a seizure while at Fieldstone Farm, beyond employing general first aid, what actions do you suggest we take?

❒ Call 9-1-1

❒ Report observations to parents/guardians immediately ❒ Allow _____ minutes to rest and reorient

_____

Student/Parent/Guardian Date Fieldstone Farm Staff Date