PO Box 172, Ridgway, PA 15853
www.bigmaplefarmnt.net
bmfntinc@gmail.com
(814) 387-3571

Dear Friend,

Thank you for your interest in Big Maple Farm's Natural Therapies, Inc. To become a rider, it is necessary to have the enclosed forms completed and returned to us as soon as possible. There may be a waiting period to get a scheduled session time depending on openings. We will be in touch with you. The enclosed forms are to be returned at least seven days prior to start of lessons.

At the end of the Packet you will find a letter to provide to your health care provider. Please note that no lessons can commence with out this form on file. Please know that all information is treated as highly confidential,

A registration fee of $30.00 is payable **once per calendar year**. The fee is to be submitted with the rider's application to participate in a session of lessons, and it is indicated on that form. The registration fee will be used to supplement current administrative costs and program insurance.

In the event that partial or full sponsorship for lessons is needed, we ask the rider to help us find a sponsor for them or reach out regarding scholarship opportunities. BMFNT does not want to turn any rider away for financial reasons.

If you have not visited the program, please call for an appointment at 814-387-3571. Please do not wait for us to call you. We look forward to meeting and working with you.

Sincerely,

Amanda Balon
Executive Director

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THERAPEUTIC RIDER REGISTRATION INFORMATION

Name: _____ Date of Birth _____

Address: _____

School or Employer: _____

Parent or Guardian (If under 18) : _____

Phone: _____ Email: _____

$30 Registration FEE Paid by (REGISTRATION IS NOT VALID WITHOUT FEE):
Check □ Cash □ Paypal □

PHOTO RELEASE

Please Check One: I DO□ DO NOT □

Consent to and authorize the use of reproduction by Big Maple Farm's Natural Therapies, Inc. of any and all photographs and any other audio/visual material taken of me/my child/my ward for promotional materials, educational activities, exhibitions, or for any other use for the benefit of the organization .

_____ _____

Signature (Parent/guardian signature if under 18) Date

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Assumption of Risk, Release of Liability and Indemnification Agreement for 2022

BIG MAPLE FARM'S NATURAL THERAPIES, INC. (BMFNT) is in the business of organizing, conducting and providing horses, equipment, and facilities for equestrian activities, which activities include but are not limited to, providing open rides clinics and related equestrian training referred to herein as the "activities." The undersigned desires to participate in the activities.

NOW THEREFORE AND IN CONSIDERATION of being allowed to participate in any way in one or more of the activities as the context requires, I acknowledge, appreciate and agree that:

1. **GENERAL**. Risks of activities include, but are not limited to, death, personal injury, loss of income or the enjoyment of life, and pain, and scarring or disfigurement. The causes of possible injury are many, including but not limited to; injury from bodily contact, incidental or inherent in the nature of the activities, slipping and falling or tripping on surfaces, regardless of physical or environmental conditions, injury from equestrian activities or horseback riding; injury due to supervision or lack of supervision by Big Maple Farm's Natural Therapies' employees or agents, including trainers or instructors, or rules or regulations and instructions (or lack thereof) regarding the use of equipment or to the nature of the activity itself, or injury caused by other participants' and malicious acts of other participants, regardless of whether Big Maple Farm's Natural Therapies had or should have had knowledge of the likelihood of malicious acts by such participant.
2. **ASSUMPTION OF RISK**. I KNOWINGLY AND FREELY ASSUME ALL RISKS RELATED TO OR ARISING OUT OF ANY ACTIVITIES, both known and unknown, including any injury or action caused by that harms or injuries in any way a pedestrian or nonparticipant, or action caused by me that harms or injures in any way a pedestrian or nonparticipant, or others, EVEN IF ARISING FROM THE NEGLIGENCE< GROSS NEGLIGENCE OR RECKLESS DISREGARD OF THE RELEASES (as defined in the next paragraph) or others and assume full responsibility for my participation.
3. **RELEASES FROM LIABILITY.** I, for myself and on behalf of my heirs, assigns, personal representatives and whomever else may have an interest either at common law or by operation of statue, HEREBY RELEASE, WAIVE, RELINQUISH, DISCHARGE AND COVENANT NOT TO SUE BMFNT, its' employees, volunteers, other participants, and if applicable, owners and lessors of premises use to conduct the activities ("Releases"), FROM LIABILITY FROM ANY AND ALL CLAIMS OR LIABILITIES FOR ALL AND ANY INJURY, DISABILITY, DEATH, OR LOSS OF DAMAGE TO MYSELF, ANY PERSON OR PROPERTY, WHETHER ARISING FROM THE NEGLIGENCE, GROSS NEGLIGENCE OR RELECKLESS DISREGARD OF THE RELEASES OR OTHERWISE, SUSTAINED AS A RESULT OF ARISING OUT OF, OR RELATED TO ANY ACTIVITIES, to the fullest extent permitted by law.
4. **REPRESENTATIONS AND WARRANTIES**. I represent and warrant I am in good physical condition and able to safely participate in any activities. I acknowledge that BMFNT has made no recommendations or determinations as to my fitness or ability to participate in any activities. I further agree that I will not participate in any activities or use any equipment unless and until I determine that I have thoroughly familiarized myself with the correct use and operation thereof.
5. **SEVERABILITY.** I expressly agree that this agreement is intended to be as broad and inclusive as is permitted by the international laws of the Commonwealth of Pennsylvania and that if any portion thereof is invalid, it is agreed that the balance shall, not withstanding, continue in full legal force and effect.
6. **MISCELLANEOUS.** This agreement is entered into Elk County, Pennsylvania and shall be constructed under the internal law of the Commonwealth of Pennsylvania in Elk county, Pennsylvania. I HAVE READ THIS ASSUMPTION OF RISK, RELEASE OF LIABILITY AND INDEMNIFICATION AGREEMENT, FULLY UNDERSTAND ITS TERM, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, INCLUDING THE RIGHT TO SUE, AND SIGN IT FREELY AND VOLUNTARILY AND INTEND TO COMPLETELY AND UNCONDITIONALLY RELEASE BIG MAPLE FARM'S NATURAL THERAPIES, INC. FROM ALL LIABILITY IN CONNECTION WITH MY PARTICIPATION IN, OR ATTENDANCE OF AND ACTIVITIES.

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PARTICIPANTS OVER THE AGE OF 18

This is to certify that I do consent and agree to assumption of risk, release from liability and indemnification as provided herein with all the Releases, and , for myself, my heirs, assigns, and next of kin. I release and agree to indemnify and hold harmless the RELEASES from all and any liabilities incident to my involvement or participation in any Activities as provided herein, EVEN IF ARISING FROM NEGLIGENCE, GROSS NEGLIGENCE OR RECKLESS DISREGARD OF THE RELEASES, to the fullest extent permitted by law.

- Accepted and agreed effective as of _____/_____/_____
- Signature of Participant _____
- Print Name of Participant _____
- Participant Address _____

PARTICIPANTS UNDER THE AGE OF 18

This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her assumption of risk, release from liability and indemnification as provided above with all the Releases, and, for myself, my heirs, assigns, and next of kin, I release and agree to indemnify and hold harmless the RELEASES from all and any liabilities incident to my minor child's involvement or participation in any Activities as provided above, EVEN IF ARISING FROM NEGLIGENCE, GROSS NEGLIGENCE OR RECKLESS DISREGARD OF THE RELEASES, to the fullest extent permitted by law.

- Accepted and agreed effective as of _____/_____/_____
- PRINT Name of Participant _____
- SIGNATURE OF PARTICIPANT _____
- PRINT Name of Parent/Guardian and Relationship
  _____
- SIGNATURE of Parent/Guardian
  _____
- Address of Participants Parent/or Guardian
  _____

_____

City State Zip

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CONFIDENTIALITY POLICY

It is the policy of Big Maple Farm's Natural Therapies, Inc. to keep confidential all medical, social, referral, personal, and financial information regarding participants, volunteers, and staff. This information will not be shared or disclosed to individuals outside the operation of the center without the express written permission given by the individual concerned.

It is understood by all the individuals working or volunteering at this center that this confidentiality code will be maintained and adhered to in order to protect the privacy and personal dignity of all individuals associated with the day-to-day operations of this center. Confidential information may be shared between center staff in cases where it will assist planning for the equestrian lesson.

Violation of this policy by anyone at Big Maple Farm's Natural Therapies, Inc. can result in immediate expulsion from all activities at the center, as determined by the program director and the board of directors.

I understand and will observe the confidentiality policy of Big Maple Farm's Natural Therapies, Inc.

_____ _____

Signature (Parent/Guardian if Under 18) Date

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DAY AND TIME PREFERENCE

Please see our Hours of operation for the 2022 season! We can offer additional times if you need but they must be passed by our program coordinator. Please Indicate times in which you are available for lessons. Label your order of preference as 1 as most desired and 3 as lease desired.

Wednesday

- 4pm-6:30pm
  (This can be broken into Half hour/hour time intervals)

_____

Thursday

- 4pm-6:30pm
  (This can be broken into half hour/hour time intervals)

_____

Saturday

- 10am-3pm
  (This can be broken into half hour/hour time intervals)

_____

Sunday

- 1:30pm-3pm
- 5:00pm-6:30pm
  (This can be broken into half hour/hour time intervals)

_____

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BARN RULES

1. Come into the session with a positive attitude and always remember to use a calm voice while around the animals!
2. Please be sure you have the proper foot ware! Hard soles are a must!
3. EVERYONE!!!!!!! Must wear a helmet while mounted on a horse.
4. Check the Bulletin board to see your assigned horse and volunteers.
5. Be Alert
6. Be relaxed
7. Do not enter the stalls without a volunteer.
8. Always wait for assistance.
9. Be sure to ask questions.
10. Do not bring the horse into the lesson area until the lesson ahead of you is complete.
11. Enjoy yourself and build a connection with the horse.
12. At the end of the lesson be sure to reward the horse with their treat from the buckets not your hands!!!!

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Dear Health Care Provider,

Your patient is interested in supervised equine activities. In order to safely provide this service, Big Maple Farm's Natural Therapies, Inc. requests that you complete the attached form.

Please note that the following conditions may suggest precautions and contraindication to therapeutic horseback riding. Therefore, when completing the form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability
Coxa Arthrosis
Cranial Defects
Heterotopic Ossification
Myositis Ossificans
Joint Subluxation/Dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

Psychological
Substance Abuse
Thought Control Disorders
Weight Control Disorders
Animal Abuse
Physically Abusive
Sexually Abusive
Emotionally Abusive

Other
Age – Under 4 Years

Medical
Allergies
Blood Pressure Control
Heart Conditions
Hemophilia
Medical Instability
Migraines
Peripheral Vascular Disease
Respiratory Compromise
Recent Surgeries
Indwelling Catheters
Medications- i.e. Photosensitivity
Poor Endurance
Skin Breakdown

Neurological
Hydrocephalus/Shunt
Seizure
Spina Bifida
Chiari II Malformation
Tethered Cord
Hydromyelia

Thank you very much for your assistance. If you have any further questions or concerns regarding the patient's participation in equine activities, please feel free to contact us at the address above, or call 814-387-3571.

Sincerely,

Amanda Balon
Executive Director

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Participant Medical History

Name _____
Date of Birth_____ Height _____ Weight_____
Diagnosis_____ Date of Onset _____
Past/Prospective Surgeries _____
Medications_____
Seizures □Yes □ No Type _____ Last Seizure Date _____
Shunt Present □ Yes □ No Date of Last Revision _____
Special Precautions/Needs
_____
_____
Mobility (Check One):
□ Independent Ambulation □ Assisted Ambulation □ Wheelchair
Braces/Assistive Devices _____
*For Persons with Down Syndrome:
□ Negative X-Ray for Atlantoaxial Instability Date _____
□ Negative for Clinical Symptoms of Atlantoaxial Instability

Areas	**Yes**	**No**	**Comments**
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Emotional/Psychological			
Other:			

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities.

Physician's Name _____ Title _____
Signature _____ Date _____
Address _____
Phone _____ License/UPIN Number_____