Participant Registration Form

SUNRISE INC
THERAPEUTIC HORSEBACK RIDING CENTER

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

1052 Gurney Drive, Richmond, IN (765) 983-1500 www.Sunrisetrc.com

Must be updated in January each year for ALL participants.

PARTICIPANT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Age: _____

Gender (circle): Male Female Transgender Nonbinary Other: _____

Address: _____

City: _____ State: _____ ZIP: _____

Email (primary email for billing & correspondence): _____

Primary Phone (circle one - home / cell): _____

For Adult Participants (18 and up):

Secondary Phone (circle one - cell / home / work): _____

School or institution you're currently attending: _____

Participant is (choose one): ◯ Minor ◯ Adult with a Legal Guardian ◯ Independent Adult

Is the participant a veteran or active military member of the U.S. Armed Forces? **(circle one)** YES NO

FOR MINORS OR ADULTS WITH LEGAL GUARDIANS (REQUIRED)

Parent or Guardian Name: _____ Occupation: _____

Employer: _____ Work phone: _____

Cell phone: _____ Email: _____

Address if different from participant:

_____

Relationship to Participant: ◯ Parent ◯ Child ◯ Grandparent ◯ Spouse ◯ Other: _____

Parent or Guardian Name: _____ Occupation: _____

Employer: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Address if different from participant:

_____

Relationship to Participant: ◯ Parent ◯ Child ◯ Grandparent ◯ Spouse ◯ Other: _____

Name & phone number of anyone else who may transport or be responsible for participant:

_____

_____

IN CASE OF EMERGENCY

Physician Name: _____ Physician Phone: _____

Preferred Medical Facility / Hospital: _____

Health Insurance Company: _____

Policy Number: _____

Known Allergies (environmental, food, medication):

_____

_____

Current Medications:

_____

_____

Are you taking any medications that make you photosensitive? If so, what? _____

Things I want emergency responders to know about me:

_____

_____

In the event of a medical emergency Sunrise Inc. will provide basic first aid, and/or call 911 including disclosing all pertinent and available healthcare information to emergency medical personnel.

Please list ***AT MINIMUM TWO*** Emergency Contact names and phone numbers:

#1 - Emergency Contact Name: _____ Phone: _____

#2 - Emergency Contact Name: _____ Phone: _____

#3 - Emergency Contact Name: _____ Phone: _____

PAYMENT POLICY

Fees are expected to be paid for at the beginning of each session in full unless otherwise arranged with the Program Director or Executive Director. If a payment is not made for two consecutive weeks, the participant will be removed from the session at the discretion of the Program Director or Executive Director. All fees must be paid in full before participants may register for another session.

I have read and understand this policy.

SIGNATURE: _____ **DATE:** _____

PARTICIPANT HEALTH HISTORY

Participant Name:_____ Date of Birth: _____

Height (required): _____ Current Weight (required): _____

List ALL Diagnoses or Disabilities & year of onset: _____

_____

_____

If the participant has ever been treated for any of the items below, please check the box and provide date of occurrence and details.

YES	Medical Condition or Disability	Date	Details
	Down Syndrome		
	Spinal condition (injury, scoliosis, fusion, spina bifida, etc.)		
	Brain condition (Cerebral Palsy, stroke, etc.)		
	Bleeding or clotting disorder		
	Diabetes		
	Joint complications (hip dysplasia, joint replacement / arthritis, etc.)		
	Epilepsy (please provide date of most recent seizure in details)		
	Heart conditions (pacemakers, tachycardia, arrythmia, etc.)		
	Neurological conditions (hydrocephalus, mitochonrdial disorder, multiple sclerosis, etc.)		
	Pulmonary conditions (asthma, cancer, emphysema, etc.)		
	Skin integrity issues / breakdown or pressure sores		
	Medical shunts, feeding tubes, or any other indwelling equipment?		

PARTICIPANT HEALTH HISTORY CONT.

In the past 12 months has the participant experienced any of the medical events below? If yes, please provide details (date of occurrence, care provided) in the box to the right.

YES	Medical Event	Details
	Loss of conciousness, including seizures	
	Any seizure activity for any reason	
	Hospitalization for a mental health crisis	
	Hospitalization for any serious injury, condition or surgery	
	Activity restrictions due to medical reasons	
	The need for assistance to maintain an upright sitting position or control of the head	
	A medical device such as an insulin pump, catheter, colostomy bag, or any other indwelling medical device(s)	
	Hearing issues	
	Vision issues	
	Speech issues	
	Immune deficiency	
	Circulation	
	Cognitive development	
	Fatigue or limited endurance	
	Muscular	
	Orthopedic (joints / spine / bones)	

PARTICIPANT HEALTH HISTORY CONT.

YES	Medical Event	Details
	Emotional or psychological condition(s)	
	Behavior	
	Balance issues	
	Tactile / sensation issues	
	Digestion / elimination	
	Learning disabilities	
	Allergies	
	Other:	

MEDICATIONS & MEDICAL EQUIPMENT

Does the participant have or use:

YES	Medical Event	Details
	Asthma & carries an inhaler or other medication	
	Severe allergy & carries an EpiPen	
	Walker	
	Crutches	
	Wheelchair	
	Body brace(s) of any type	

IMPORTANT INFORMATION ABOUT MEDICAL AND HEALTH HISTORY

Sunrise Inc. reserves the right to request additional information from participant's medical or therapy team 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. Some medical conditions may qualify as a contraindication through PATH International and will not allow the participant to qualify for services from our insurance provider. At which point therapeutic riding will not be available to the participant, but other programs may. Sunrise Inc. will refer certain participants to centers who provide hippotherapy should they not meet criteria for therapeutic riding.

I hereby affirm that, to the best of my knowledge, the health history information is complete and correct.

Name of person completing the form: _____ Date: _____

Signature: _____ Relationship to Participant: _____

RIDER WEIGHT POLICY

Sunrise inc. adheres to the following guidelines when making decisions regarding rider weight and therapeutic riding participation. Each guideline is in place to ensure each member of the team (horse, rider and volunteer) has a safe experience. Horse health, rider's weight distribution, rider's movement patterns and volunteer's abilities to safely assist a rider are all important considerations in these guidelines.

- Each horse will be evaluated individually by program staff and assigned a maximum carrying weight. Considerations will be made for age and health / soundness.
- Each rider will be evaluated individually by instructional staff. considerations will be made for rider's height, range of motion, balance and ability to mount / dismount independently.
- Each team will be evaluated by instructional staff to ensure that an appropriate volunteer / instructor is available to complete all emergency procedures.
- The following rider balance and weight ratios will generally be followed. Riders may be asked to weight-in on Sunrise Inc. scales at any point during their riding session.
- Each rider is reviewed by at least two Sunrise Inc. program staff. If a rider is determined to be over the weight limit of available Sunrise Inc. horses, the participant has the option to participate in unmounted therapeutic horsemanship. Participants may reapply for mounted activities in the event of a weight change.

Rider Weight	Balance	Meets Criteria?
Up to 175 lbs	Balanced	YES
150 lbs or greater	Unbalanced	NO

I have read and understand the CKRH rider weight policy.

Signature: _____ Relationship to Participant: _____

LIABILITY RELEASE

_____ (Participant's name) would like to participant in the Sunrise Inc. therapeutic riding program. I acknowledge the risks and potential for risks of horseback riding, hippotherapy, and horse related activities and therapies; However, I feel that the possible benefits to myself / my son / my daughter / my ward are greater than the risk 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, known or unknown whether existing on the date of agreement or in the future, against Sunrise Inc., their Board of Directors, Employees, Instructors, Therapists, Aides, Volunteers, Equine, Equine Owners, Equipment, Earlham College, and Operating Site for any and all injuries and/or losses I / my son / my daughter / my ward may sustain while participating at Sunrise Inc.

"WARNING: Under Indiana Citation IN ST 34-31-5-1, An equine activity sponsor or equine professional is not liable for: (1) an injury to a participant; or (2) the death of a participant; resulting from an inherent risk of equine activities. (b) subject to section 2 of this chapter, a participant or participant's representative may not: (1) make a claim against; (2) maintain an action against; or (3) recover from; an equine activity sponsor or equine professional for injury, loss, damage, or death of the participant resulting from an inherent risk of equine activities.

SIGNATURE:_____ DATE:_____

PATH INTL., AUTHORIZATION FOR IMAGE USAGE
PHOTO RELEASE

◯ **I CONSENT** ◯ **I DO NOT CONSENT**

I hereby irrevocably grant to the Professional Association of Therapeutic Horsemanship International (PATH Intl.) ("Organization") the right in perpetuity throughout the world, and in all now known and hereafter existing media, and in any language, to use my name, photograph, picture, video, physical likeness and/or voice for any reasonable purpose, including the organization's exhibition, distribution, or promotion of the organization on any media platform that exists now or in the future.

I agree that the foregoing grant includes the right to use my physical likeness in any for, including, without limitation, a photograph, picture, video, artistic rendering, silhouette or other reproduction by photograph, film, tape, or otherwise.

I hereby certify and represent that I have read the foregoing and fully understand the meaning and effect thereof, and intending to be legally bound I have signed this authorization.

SUNRISE INC. AUTHORIZATION FOR IMAGE USAGE PHOTO RELEASE

I consent to and authorize the use and reproduction by CKRH, Inc. of any and all photographs and any other audio-visual materials taken of me for promotional material, educational activities, exhibits, electronic publications (including World Wide Web) or for any other use for the benefit of the program.

◯ **I AGREE** ◯ **I DO NOT AGREE**

SIGNATURE:_____ **DATE:**_____