Equine Memory Cafe at the Ridge

Moments in Motion

PARTICIPANT APPLICATION/ REGISTRATION - 2025

BLUFF & RIDGE
Equine Assisted Therapies, INC

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International
Member

Name of Participant_____ _____ DOB_____ Height _____Weight _____

Care Partner's Name: _____

Address _____Phone _____

City, State, Zip _____

E-mail _____

Current Living Situation (At home/Assisted Living, etc.) _____

How long?

Optional (for our grant writing purposes only) Gender: _ _ Race:

EMERGENCY CONTACT (if other than Care Partner)

Name _____ Phone _____

Relationship _____ Cell _____

Participant Health Information

Primary Diagnosis:

Secondary Diagnosis:

Physical Disabilities/Limitations:

DNR (do-not-resuscitate) Status:

Allergies:

Mobility:IndependentAmbulation ☐ Y ☐N Assisted Ambulation ☐Y ☐ N
N Wheelchair ☐ Y ☐ N

Participant Profile:

Strengths & Abilities:

Mailing Address: Bluff & Ridge Equine Assisted Therapies, Inc. (BLUFF & RIDGE)
30662 Moccasin Avenue; Kendall, WI 54638

Presenting Problems/Concerns

Important Life experiences, values or interests (ie: career, family, favorite style of music, hobby):

Participant's daily activities and routine:

Past interactions with horses, animals or farms:

Goals (personal, family, horsemanship)

HOW DID YOU HEAR ABOUT BLUFF & RIDGW EQUINE-ASSISTED

THERAPIES, INC.? ☐Newspaper ☐ Website ☐ Facebook ☐ Radio/TV ☐ Poster

☐ A Volunteer ☐ Another Organization ☐ Other (please describe):

IS THERE ADDITIONAL INFORMATION OR COMMENTS YOU FEEL WOULD BE HELPFUL TO BLUFF & RIDGE EQUINE-ASSISTED THERAPIES, INC.?

BLUFF & RIDGE EQUINE-ASSISTED THERAPIES, INC.

LIABILITY, PHOTO, MEDICAL CONSENT RELEASE
NEEDS TO BE COMPLETED FOR ALL PARTICIPANTS, VOLUNTEERS and STAFF
PARENT/GUARDIAND SIGNATURE FOR ANY PARTICIPANT UNDER AGE OF 18

LIBILITY RELEASE

I/ my child/ my ward would like to participate in the Bluff & Ridge Equine-Assisted Therapies, Inc. (BREATHE) Program as a rider, volunteer, or staff person. I acknowledge the risk and hazardous nature of horse activities and horseback riding. However, I feel that the possible benefits are greater than the risks assumed. I hereby, intending to be legally bound for myself, my heirs, assigns, executors or administrators, waive and release forever all claims for damages against Bluff & Ridge Equine-Assisted Therapies, Inc., its Board of Directors, instructors, therapists, aides, volunteers, horse owners and/or employees for any and all injuries and/or losses that I/ my child/ my ward may sustain while traveling to or from, or participating in any BREATHE activities.

Signature: _____Date: _____

Parent or Guardian: _____ Date: _____

Wisconsin State Statutes Sec. 95.481

Notice: A person who is engaged for compensation in the rental of equines or equine equipment or tack in the instruction of a person in the riding or driving of equine or in being a passenger upon an equine is not liable for injury or death of a person involved in equine activities resulting from the inherent risks of equine activities, as defined in Section 895.481 (1) (e) of the Wisconsin State Statutes.

PHOTO RELEASE

I ☐ DO ☐DO NOT consent to and authorize the use and reproduction by Bluff & Ridge Equine-Assisted Therapies, Inc., of all photographs and any other audio/visual material taken of me for promotional material, educational activities, exhibitions or another use for the benefit of the program.

Signature: _____Date: _____

Parent or Guardian: _____ Date:_____

MEDICAL TREATMENT CONSENT PLAN

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or any other use for benefit of the agency.

I authorize Bluff & Ridge Equine-Assisted Therapies, Inc. to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the emergency medical treatment. This authorization includes x-ray, hospitalization, medication, and any treatment procedure deemed “life-saving” by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Consent Signature _____Date _____

MEDICAL TREATMENT NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. Parent or legal guardian will always remain on site during equine assisted activities. In the event emergency treatment/aid is required, I wish the following procedure to take place:

Non-Consent Signature _____Date _____

Mailing Address: Bluff & Ridge Equine Assisted Therapies, Inc. (BLUFF & RIDGE)
23797 County Highway CM, Tomah, WI 54660