



**Veteran Services at Bluff & Ridge  
PARTICIPANT APPLICATION/  
REGISTRATION**



Name of Participant \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

E-mail: \_\_\_\_\_

Branch of Military Service: \_\_\_\_\_

Years of Service: \_\_\_\_\_

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

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_ Cell \_\_\_\_\_

**Participant Health Information**

Primary Diagnosis:

Secondary Diagnosis:

Physical Disabilities/Limitations:

Allergies:

Mobility: Independent Ambulation  Y  N Assisted Ambulation  Y  N  
N Wheelchair  Y  N

Participant Profile:

Strengths & Abilities:

What would you like to accomplish/achieve by participating in Equine Assisted Services?

Do you have any history of therapy or treatment related to mental health and well-being?

Past interactions with horses, animals or farms:

Goals (personal, family, horsemanship)

HOW DID YOU HEAR ABOUT BLUFF & RIDGE 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.?

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



**BLUFF & RIDGE EQUINE-ASSISTED THERAPIES, INC.**



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

**LIABILITY RELEASE**

I/ my child/ my ward would like to participate in the Bluff & Ridge Equine-Assisted Therapies, Inc. (Bluff & Ridge) 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 Bluff & Ridge 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 \_\_\_\_\_