MONTGOMERY AREA NON-TRADITIONAL EQUESTRIANS

Participant Application

To be completed by mentally competent adult participant or participant's parent or legal guardian (if under age 18) prior to consideration for program participation. Must be updated annually.

GENERAL INFORMATION

Participant's Name: _____ Birth date: _____

Height: _____ Weight: _____ Gender: M F

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Parent (or Legal Guardian) Information (required if participant is under age 18 or is a dependent adult):

Parent/Guardian Name: _____ Phone Number: _____

Parent/Guardian Name: _____ Phone Number: _____

Emergency Contact (required): _____ Phone Number: _____

Employer/School: _____ Phone Number: _____

PARTICIPANT'S HEALTH HISTORY

Primary Diagnosis: _____ Approximate Date of Onset: _____

Secondary Diagnoses: _____

Please check all of the following conditions that apply to participant:

- o Atlantoaxial Instability
- o Coxa Arthrosis
- o Heterotopic Ossification
- o Myositis Ossificans
- o Joint Subluxation/Dislocation
- o Osteoporosis
- o Neuromuscular Disorder/ MS
- o Spinal Joint Fusion/Fixation
- o Spinal Joint Instability/Abnormalities
- o Spinal Curvature/Scoliosis
- o Hydrocephalus
- o Shunt
- o Seizure
- o Spina Bifida
- o Chiari II Malformation
- o Tethered Cord
- o Hydromyelia
- o Allergies
- o Animal Abuser
- o Cardiac Condition
- o Physical/Sexual/Emotional Abuser or Victim
- o Blood Pressure Control
- o Dangerous to Self
- o Dangerous to Others
- o Diabetes
- o Fire Setter
- o Hemophilia
- o Hearing impaired
- o Non-Verbal or speech impaired
- o Medical Instability
- o Migraines
- o PVD
- o Respiratory Compromise
- o Recent Surgeries
- o Substance Abuse
- o Thought Control Disorder
- o Weight Control Disorder
- o Under 4 Years Old
- o Indwelling Catheter
- o Photosensitivity
- o Medication Precautions
- o Poor Endurance
- o Skin Disorder
- o Joint Replacement
- o Pathologic Fractures
- o Exacerbations of medical conditions (i.e. RA, MS)
- o Down Syndrome
- o Cranial Deficits
- o Sensory Deficit
- o Autism Spectrum Disorder
- o Any other condition which might reasonably affect participant's horse riding or other activities at MANE

Comments: _____

_____

Allergies (drugs, plants, animals or otherwise): _____

Recent Surgeries: _____

Current Medications (include prescription and over the counter medications but not vitamins): _____

_____

If any of the above information changes during MANE's program year, please promptly advise MANE by phone (334-213-0909) and in writing (3699 Wallahatchie Road, Pike Road, Alabama, 36064).

Participant Name _____ Date _____

MONTGOMERY AREA NON-TRADITIONAL EQUESTRIANS

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is, in MANE's judgment, required due to participant's illness or injury while on MANE's property or under MANE's supervision elsewhere, Montgomery Area Nontraditional Equestrians, Inc. ("MANE") is authorized to do the following:

1. secure and retain medical treatment and transportation if necessary;
2. release MANE records (including this application) upon request to the individual or agency involved in the medical emergency treatment; and/or
3. take additional action as MANE determines in its sole discretion are appropriate to protect participant's life, health and/or welfare.

This authorization includes but is not limited to radiographic or other imaging, surgery, hospitalization, medication and any treatment or procedure deemed "life-saving" by an attending physician, paramedic, nurse or other healthcare provider. This provision will only be invoked if the participant's parent(s)/legal guardian(s) and emergency contact(s) provided above cannot be reached within a reasonable time, giving consideration to the severity of participant's injury or illness. However, if the participant is a mentally competent adult and is able to give such authorization on his or her own behalf, MANE may act on the participant's own authorization.

Signature*: _____ Date: _____
Name (Print): _____
*Signature must be that of mentally competent adult participant or parent/legal guardian of participant under 18 years of age.

PHOTOGRAPHY CONSENT

MANE often takes still pictures and/or videos of participants, volunteers and instructors. This is done for several reasons. Rider progress and acquisition of skills provide instructors and participants helpful information and positive feedback. Photos and videos are also used in brochures, presentations, posters, and on our website for publicity. Additionally, they are occasionally provided to participants for keepsakes. Consent to such photography and such use thereof is hereby given.

Signature* (indicates CONSENT): _____
Name (Print) : _____ Date _____ *Signature must be that of a mentally competent adult participant or parent/legal guardian of participant under 18 years of age.

Participant Name _____ Date _____

MONTGOMERY AREA NON-TRADITIONAL EQUESTRIANS

Release of Liability and Indemnity

To be completed by a mentally competent adult participant or participant's parent or legal guardian if under age 18.

This Release of Liability and Indemnity ("Release") is made and entered into as of _____, by and between Montgomery Area Nontraditional Equestrians, Inc., hereinafter known as MANE, on the one hand, and its employee staff/non-employee instructor/rider or other participant/volunteer (print name), _____, each hereinafter known as a "Releasor", on the other hand. In return for participation in some capacity in MANE's therapeutic horseback riding or other activities, work activities, special events and fundraisers, Releasor, on his/her own behalf and on behalf of his/her heirs, successors, assigns, and personal representatives, hereby expressly agrees to the following:

1. Releasor agrees to assume any and all risks involved in or arising from Releasor's participation in any such activities or presence upon MANE's property and facilities or elsewhere, including, without limitation, the risks of death, bodily injury, property damage, falls, kicks, bites, collisions with vehicles, horses or stationary objects, fire or explosion, the unavailability of emergency medical care, or the negligence or deliberate act of another person; provided, however, no MANE employee or non-employee instructor assumes the risk of the direct willful and wanton negligence or unlawful conduct of another MANE employee or non-employee instructor.

2. Each Participant (being a rider or volunteer at MANE's property or facilities) agrees to hold MANE and all of its successors, assigns, subsidiaries, franchisees, affiliates, officers, directors, employees, agents, and other representatives (collectively, the "MANE Parties") completely harmless and not liable for, and releases them from all liability whatsoever, and agrees not to sue any of them on account of or in connection with, any claims, causes of action, injuries, damages, costs or expenses, arising out of such Participant's participation in any of the activities or events described in this Release and/or presence upon MANE's property and facilities or elsewhere, including without limitation, those based on death, bodily injury, property damage, including punitive and consequential damages, unless the damages, injury or death are caused by the direct willful and wanton negligence or unlawful conduct of MANE.

3. Each Participant agrees to waive the protection afforded by any statute or law in any jurisdiction whose purpose, substance and/or effect is to provide that a general release shall not extend to claims, material, or otherwise, which the person giving the release does not know or suspect to exist at the time of executing the release.

4. Each Participant agrees to indemnify and defend the MANE Parties against, and hold them harmless from, any and all claims, causes of action, damages, judgments, costs, or expenses, including court costs and reasonable attorney's fees at trial and all appellate levels, which in any way arise from such Participant's participation in any of the activities described in this Release and/or Participant's presence upon MANE's property or facilities or elsewhere.

5. This Release is made and entered into the State of Alabama and shall be enforced and interpreted under the internal laws of such state. If any clause herein conflicts with such state's law or federal law, then that clause shall be null and void, but the remainder of this Release shall remain in full force and effect. When MANE and a Releasor or a Releasor's parent or legal guardian signs this Release, it will then be binding on such parties, subject to the above terms and conditions. This Release may not be amended except in writing and shall be binding upon the parties' respective heirs, personal representatives, successors and assigns, and shall run in favor of each of the MANE Parties and their respective heirs, personal representatives, successors and assigns.

6. Nothing in this Release shall be applied or interpreted to deny or limit in any way the immunities, benefits and other protections afforded the MANE Parties under the Alabama Equine Activities Liability Protection Act or under any other applicable law.

RELEASOR **MANE REPRESENTATIVE**

Signature*: _____Date: _____ Signature: _____ Date: _____

Name (Print): _____ Name (Print): _____

*Signature must be that of mentally competent adult participant or parent/legal guardian of participant under 18 years of age, volunteer, employee, or non-employee instructor.

Participant Name _____ Date _____

MONTGOMERY AREA NON-TRADITIONAL EQUESTRIANS

Physician's Statement

To be completed by the participant's licensed physician.

The patient listed below ("Participant") is interested in participating in supervised therapeutic horseback riding activities conducted by Montgomery Area Nontraditional Equestrians, Inc. ("MANE"). In order to provide this service, MANE requests that you complete the following medical history and release for riding.

Participant: _____ DOB: _____ Height: _____ Weight: _____
Primary Diagnosis: _____Approximate Date of Onset: _____
Secondary Diagnoses: _____
Past Surgeries: _____
Prospective Surgeries: _____
Current Medications: _____
Please indicate any special precautions/needs: _____

FOR RIDERS WITH DOWN SYNDROME

Prior to participating in any mounted activities, a medical examination with special reference to neurologic function must not reveal Participant's having an atlantoaxial instability or focal neurologic disorder. Additionally, Participants must have an annual medical clearance from a licensed physician that includes a neurological exam that specifically denies any symptoms consistent with atlantoaxial instability or with focal neurologic disorder.

Participant is negative for clinical symptoms of atlantoaxial instability or of focal neurologic disorder.

Date of Examination: _____

PRECAUTIONS AND CONTRAINDICATIONS

Please note that the following conditions may suggest precautions and contraindications to Participant's therapeutic horseback riding. Please indicate whether or not these conditions are present for Participant and, if so, to what degree (mild, moderate, or severe).

Orthopedic

Atlantoaxial Instability	Y	N	_____
Coxa Arthrosis	Y	N	_____
Cranial Deficits	Y	N	_____
Heterotopic/ Myositis Ossification	Y	N	_____
Joint subluxation/dislocation	Y	N	_____
Osteoporosis	Y	N	_____
Pathologic Fractures	Y	N	_____
Spinal Joint Fusion/Fixation	Y	N	_____
Spinal Joint Instability/Abnormalities	Y	N	_____
Spinal Curvature/Scoliosis	Y	N	_____
Joint replacement	Y	N	_____

Neurologic

Autism Spectrum Disorder [?]	Y	N	_____
Hydrocephalus	Y	N	_____
Sensory Deficit	Y	N	_____
Seizure	Y	N	_____
Date of Last Seizure: _____			
Spina Bifida	Y	N	_____
Chiari II malformation	Y	N	_____
Tethered Cord	Y	N	_____

Participant Name _____ Date _____

Hydromyelia	Y	N	_____
Neuromuscular Disorder/MS Spinal	Y	N	_____
Fusion/Fixation	Y	N	_____

Medical/Psychological

Cardiac Condition	Y	N	_____
Shunt	Y	N	_____
Physical/Sexual/Emotional Abuser or Victim	Y	N	_____
Blood Pressure Control	Y	N	_____
Exacerbations of medical conditions (i.e. RA, MS)	Y	N	_____
Hemophilia	Y	N	_____
Medical Instability	Y	N	_____
Migraines	Y	N	_____
PVD	Y	N	_____
Respiratory Compromise	Y	N	_____
Substance Abuse	Y	N	_____
Thought Control Disorder	Y	N	_____
Weight Control Disorder	Y	N	_____
Allergies	Y	N	_____
Animal Abuse	Y	N	_____
Dangerous to self and/or others	Y	N	_____
Diabetes	Y	N	_____
Hearing impaired	Y	N	_____
Non-verbal or speech impaired	Y	N	_____
Fire setter	Y	N	_____
Poor endurance	Y	N	_____
Skin disorder	Y	N	_____
Indwelling catheter	Y	N	_____
Photosensitivity	Y	N	_____

Please specify any other condition which might reasonably affect Participant's riding or other activities at MANE

_____

_____

Comments: _____

Known Allergies (drugs, plants, animals or otherwise): _____

_____

Recent Surgeries: _____

To my knowledge, there is no reason why this individual should not participate in supervised equine activities. However, I understand that MANE will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this individual's abilities and limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Signature: _____ Date: _____

Name/Title: _____ License/UPIN Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____

Please complete, sign and return this form to MANE.

3699 Wallahatchie Road, Pike Road AL 36064 | (334)-213-0909 | www.maneweb.org

Participant Name _____ Date _____