Rider Sign-up Package

Kona Program
73-1417 Kahakea Pl.
Kailua-Kona, Hi 96740
808-937-7903; fax 808-327-6296
www.thhkona.org; nannygirl@hawaii.rr.com

Kona Program

RELEASE AGREEMENT

THERAPEUTIC HORSEMANSHIP OF HAWAII, INC AND CONTRIBUTORS

I, the undersigned, understand that Hawaii Law (Act 249, 1994 Hawaii Legislative Session, effective June 29, 1994) limits the civil liability of persons sponsoring equine (horse, pony, mule, donkey, or hinney) activities. I understand that there are inherent risks of injury, including death, when participating in an equine activity, which risks include but are not limited to 1) the propensity of an equine to behave in ways that may result in injury or death to persons on or around them, 2) the unpredictability of an equine's reaction to such things as sounds, sudden movements and unfamiliar objects, persons or animals; 3) hazards such as surface and sub-surface conditions; 4) collisions with other equine or objects, and 5) the potential negligence of another participant, such as failing to maintain control over the equine, or not acting within the participant's ability. Knowing and understanding the risks of participating in an equine activity; including injury and death to my person and damage to my personal property, I expressly choose to assume these risks. Further, on behalf of myself, my heirs, successors, representatives and assigns, I hereby unconditionally release any and all claims and causes of actions against equine activity sponsor Therapeutic Horsemanship of Hawaii and Horseplay Equestrian Center, LLC and its/their owners, shareholders, officers, directors, principals, employees, agents, representatives and any other personnel for injury, including death, and for any damage to personal property which I may incur as a result of my participation in this equine activity. I, the undersigned, agree to indemnify the above-described equine activity sponsor (including its/their above described persons and entities) from any and all claims and causes of action brought by or on behalf of said participant at any time.

Rider/Volunteer/Visitor Name: ____________________________**Date:**____________

If rider is 18 or older, rider may sign here:____________________________________

Signature of rider

If rider is under 18, Parent/Guardian complete below

Parent Name (print)____

Parent Signature:____

1HORSEPLAY EQUESTRIAN CENTER, LLC
WAIVER & RELEASE OF LIABILITY FOR MINOR

In consideration of being allowed to participate in any way in activities of Horseplay Equestrian Center, LLC, owned by Cyndy DeMeter (hereafter referred to as "Horseplay"), and property owner Dr. Pat D' Angelo, their associations and/or affiliate sport & equestrian program(s), and related events and activities, I, the undersigned:

1. Agree that I will, with the minor participant and prior to participation, inspect the facilities and equipment to be used, and if I or the minor believes anything is unsafe, I or the minor will immediately advise the instructor of such condition(s) and refuse to participate.
2. Agree that the minor participant will wear an ASTM/SEI approved riding helmet at all times when riding.
3. Acknowledge and fully understand that the minor participant will be engaging in activities that involve risk of serious injury, including permanent disability and death, and severe social and economic losses which might result not only from the minor participant's own actions, but also from inactions or negligence of others, the rules of play, or the condition of the premises or of any equipment used, and, further, that there may be other risks not known or reasonably foreseeable at this time.
4. Acknowledge and fully understand that Hawaii Revised Statutes § 663B-2 provides that inherent risks of equine activities include, but are not limited to; (a) the propensity of an equine to behave in ways that may result in injury, harm, or death to persons on or around them; (b) the unpredictability of an equine's reaction to such things as sounds, sudden movement, and unfamiliar objects, persons and other animals; (c) certain hazards such as surface or subsurface conditions; (d) collisions with other equines or objects; and (e) the potential of a participant to act in a negligent manner than may contribute to injury of the participant or others, such as failing to maintain control over the animal or not acting within the participant's ability.
5. Assume, on behalf of myself and the minor participant and with full knowledge of the above and any other inherent risks which may be associated with equine activities, all the foregoing risks and accept personal responsibility for any damages following such injury, permanent disability or death. I, on behalf of myself and the minor participant, hereby waive any and all claims for personal injury or property damage of any kind which I or the minor participant or our heirs, personal representatives and next of kin may have or which may arise against Horseplay, Cyndy DeMeter, Dr. Pat D' Angelo, or their successors, assigns, affiliates, directors, officers, employees and agents, as a result of my participation in such equine activities, whether or not such injuries or damages result from negligence or legal liability. I also, on behalf of myself and the minor participant and our heirs, personal representatives and next of kin, hereby release and discharge Horseplay, Cyndy DeMeter, Dr. Pat D' Angelo, or their successors, assigns, affiliates, directors, officers, employees and agents from any and all liabilities, claims, lawsuits, losses, costs, causes of action and damages of any kind originating or in any way arising from my participation in such equine activities.

I, THE UNDERSIGNED, HEREBY DECLARE THAT I HAVE COMPLETELY READ AND UNDERSTAND THIS WAIVER AND RELEASE AND I VOLUNTARILY ACCEPT THE TERMS OF THIS WAIVER AND RELEASE FOR THE MINOR'S PARTICIPATION IN THE ACTIVITIES DESCRIBED HEREIN.

Parent or Guardian:__________________________ Date:________
(signature/relationship)
Parent or Guardian:__________________________ Date:________
(signature/relationship)
Printed Name of Participant:_______________________________

Address of Participant: ____

Medical Insurance Carrier (required):_________________________
Policy #: ________________________

Please Note: Signatures of BOTH parents required, even if absentee

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808-937-7903; e-mail nannygirl@hawaii.rr.com
Website: thhkona.org

PHOTO RELEASE

The undersigned hereby acknowledges and grants to therapeutic Horsemanship of Hawaii, Inc. permission to take or have taken still photographs, fulms, including video pictures of himself/herself and consents and authorizes Therapeutic Horsemanship of Hawaii, Inc. its advertising agencies, news media, and any other persons interested in Therapeutic Horsemanship of Hawaii Inc., and its work, to use and reproduce the photographs, films, video to circulate and publicize the same by all means including the generality of the foregoing newspapers, television media, brochures, pamphlets, instructional videos, books, and clinical materials.

With regards to the foregoing material, no inducements or promises have been made to me to secure my signature to this release other than the intention of Therapeutic Horsemanship of Hawaii, Inc. to use or allowed to be used, such photographs, films, video or materials for the primary purpose of promoting and aiding Therapeutic Horsemanship of Hawaii, Inc. and its work

____ ________________________

Signature Date

Participant's Application & Health History

GENERAL INFORMATION

Participant:____

DOB: _______________Age: ___________Height: __________Weight: __________Gender: M F

Address: ____

Phone: ___________________Email: ________________________Alternative #: ___________________

Employer/School: ____

Address: ____

Phone: ____

Parent/Legal Guardian: ____

Caregivers: ____

Address (if different from above): ____

Phone: ____

Referral Source: ____

Phone: ____

How did you hear about the program? ____

HEALTH HISTORY

Diagnosis: ____Date of Onset: __________________

Please indicate current or past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

MEDICATIONS (include prescription and over-the-counter; name, dose and frequency) ______

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

PHYSICAL FUNCTION (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

PSYCHO/SOCIAL FUNCTION (e.g.,. work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

GOALS (i.e. why are you applying for participation? What would you like to accomplish?

Signature: ________________________ Date: ________________

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EMERGENCY CONTACT INFORMATION

Name:____

In case of emergency, please contact the following:

Name:________________________ **Relationship:**______________

Phone:________________________ **Alt.phone:**________________

Name:________________________ **Relationship:**______________

Phone:________________________ **Alt. Phone:**________________

Physician:______________________ **Phone:**____________________

Preferred clinic or hospital:___________________________________

Medical Insurance:____

Policy #:____

In the event that I or my child is injured unable to respond, I give permission for THH personnel to call 911 and seek immediate medical attention.

________________________________ ____________________
Signature **Date**

(These 2 pages are only required if you have one of the conditions listed below)

Date: ________________________

Dear Health Care Provider:
Your patient ____
(participant's name)
is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability - include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia

Other
Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - e.g., Photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (e.g., RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,

THH-Kona; 73-1417 Kahakea Place, Kailua Kona, HI 96740; 808-937-7903

Participant's Medical History & Physician's Statement

Participant: ________________________________DOB: _______Height: ______Weight: ______
Address: ____
Diagnosis: ____ Date of Onset: ____________
Past/Prospective Surgeries: ____
Medications: ____
Seizure Type: ______________________________Controlled: Y N Date of Last Seizure:__________
Shunt Present: Y N Date of last revision: ____
Special Precautions/Needs: ____
____
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices: ____
For those with Down Syndrome: Neurologic Symptoms of Atlantoaxial Instability: ______ Present ______ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that the PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

Name/Title: ____________________________________MD DO NP PA Other __________

Signature: ____Date: ______________

Address: ____

Phone: (___) ___________________________License/UPIN Number: _________________________