Bon Cheval
equine therapy

Participant

As a previous volunteer, instructor, and the parent of a child who took part in our program, I have seen the positive benefits each participant receives.

It is my hope that you find Bon Cheval comfortable and inviting as you see improvements while participating in our equine programs.

Bon Cheval does not discriminate based on disability, age, religion, sex, race or ability to pay.

Thank you for your interest in our programs.

Please contact us if you have any questions.

Kim Culver

Executive Director

Equestrian Helmets

Equine-Assisted Therapy, Inc. requires every student to purchase their own helmet. It must be an **SEI Certified equestrian riding helmet** that meets or exceeds ASTM F1163-01 Standards.

Programs:

** ***Equine-Assisted Activities*** are group classes where participants are not simply riders. Based on ability level, participants learn basic horsemanship (on and off the horse), basic horse care, equipment and tacking up. Most of our participants start with this program.

To Apply:

1. Fill out the application completely.

2. Return the application to Bon Cheval (9969 Hwy D, Napoleon MO 64074) **or email**
Email the competed application to boncheval@yahoo.org.

3. We will contact you as soon as your application has been processed to let you know our current availability. If there is a waiting list for the class you request, we will keep you informed and contact you as soon as an opening is available.

Date	

PROGRAM SELECTION

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CONTACT AND PERSONAL INFORMATION			
Last Name:	**First Name:**	**Preferred Name:**	
Sex: Male Female	**Date of Birth:**	**Height:**	**Weight:**
Parent(s)/Legal Guardian(s):			
Email:	**Home Phone:**	**Cell Phone:**	
Street:		**Apt:**	
City:	**State:**	**ZIP Code:**	
Want to receive Quarterly *eNewsletter? Yes No **eNewsletters are also available via our website*			

☐ Release/Indemnification ☐ Medical completed ☐ Dr Signature _____	***OFFICE USE ONLY*** ☐ On waiting list **NO** Photos Allowed ☐ {	☐ Scheduled/ Start date_____ ☐ In Contacts ☐ Welcome email_____

HOW DID YOU HEAR ABOUT US?

Flyer TV Service Group Corporate Service Day School Tour Volunteer Match

Chamber of Commerce Special Event Other _____

Information on this form may be used in the preparation of grant applications for participant funding: however, names will be kept strictly confidential.

THERAPUTIC AND RIDING HISTORY

Participant Diagnosis:

When was the participant diagnosed? at birth as the result of an accident (accident date) other (date) (explain)

Does the participant use any of the following aids? wheelchair cane braces walker crutches Other (please explain)

Has the participant ever been involved in therapeutic horseback riding before?
No Yes If yes, when and for how long?

Other extra-curricular types of therapy the participant uses or has used in the past:

Were you referred by a medical profession or government agency?
Doctor PT OT ST Counselor Other (please explain)

What was the reason they referred you to Equine-Assisted Therapy?

WARNING: UNDER MISSOURI LAW, AN EQUINE PROFESSIONAL OR ANY EMPLOYEE THEREOF, IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES PURSUANT TO THE REVISED STATUTES OF MISSOURI. R.S.Mo.§537.325

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MORE ABOUT YOU	
My Occupation:	**Employer:**
Parent/Legal Guardian or Spouse Occupation:	
Employer:	

PROGRAM GOALS
What are your short-term goals for the riding session? (i.e. riding skills, behavioral changes, physical improvements, paying attention) Please be specific. **1.** **2.** **3.**
What are your long-term goals for the riding session? (i.e. riding skills, behavioral changes, physical improvements, paying attention) Please be specific. **1.** **2.** **3.**
What outcome would you like to see when these goals are achieved? **1.** **2.** **3.**
Additional information we need to know. (i.e. use of aids to regulate, health concerns, issues with the rider)

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Participant Authorization for Emergency Medical Treatment

This form is valid for a period of one (1) year from date signed. Please attach the completed medical history to this form.

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while on the property of the agency, I authorize Equine-Assisted Therapy, Inc. to:

1. secure and retain medical treatment and transportation if needed; and
2. release participant records upon request to authorized medical personnel.

Participant's Name:	
In the event of an emergency contact:	**Phone:**
Or contact:	**Phone:**
Physician's Name:	**Phone:**
Preferred Medical Facility:	
Health Insurance Company:	**Policy #:**

Consent

Consent is given for emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while on the property of the Equine-Assisted Therapy, Inc. This authorization includes x-rays, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by the physician. The provision will only be invoked if the participant is not responsive and the emergency contact is unable to be reached.

Date:	
Consent Signature:	*(Participant if 18 or older OR parent or legal guardian)*

Non-Consent

Consent is NOT given for emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while on the property of the Equine-Assisted Therapy, Inc. In the event emergency aid/treatment is required, I wish the following procedures to take place: _____

_____

_

Date:	
Non-consent Signature:	*(Participant if 18 or older OR parent or legal guardian)*

Photo Release

In consideration for being accepted into the Equine-Assisted Therapy, Inc. therapeutic horseback riding program and for the valuable benefits I receive from participating in the program and promoting the program I, _____, hereby authorize Bon Cheval Riding Therapy, its advertising agencies or the news media to have photographs, films or other audio-visual materials taken of the participant for promotional material, educational activities, exhibitions or for any other use for the benefit of the Bon Cheval therapeutic horseback riding program. ***I hereby indemnify and hold Bon***

Cheval harmless against any and all claims of damages arising out of the use of any such photographs or films of me or audio-visual materials containing the participants' image.

Participant if 18 or older | Parent(s) or Legal Guardian(s) if participant less than 18 years of age		
Name:	**Signature:**	**Date:**
Witness		
Name:	**Signature:**	**Date:**

I choose NOT to allow photographs, films, or other audio-visual material of myself/ my child to be used.

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Participant Release and Indemnification Agreement

I acknowledge and understand the inherent risks of equine activities and that horsemanship experiences can result in injury and even death. In consideration for being accepted into the Equine-Assisted Therapy Program and for the benefits I receive from participating in the program, I, _____, (*participant if 18 or older, parent or guardian*) hereby consent to assume the risks of _____, (*participant*) participation in the horsemanship program sponsored by Bon Cheval. I/we (*parent/legal guardian*) hereby consent to assume the risks of my/our participation in the horsemanship program sponsored by Bon Cheval.

Accordingly I hereby, intending to be legally bound, for myself, my heirs, assigns, executors, and/or administrators, waive and forever release, acquit, discharge and hold harmless, EAT, Inc.; the owners of the facilities and properties on which Bon Cheval, conducts its therapeutic and equine-related programs and activities, including but not limited to, the City Napoleon, the officers, directors, agents, employees, representatives, therapists, instructors, and volunteers of Bon Cheval and any other person associated with Bon Cheval. therapeutic and equine-related programs and activities, and the successors and assigns of each and all of the above-mentioned parties, from all manner of claims, demands, and damages of every kind and nature whatsoever I may now or in the future have against these parties due to any loss or personal injury, physical or mental condition, whether known or unknown to myself, and the treatment thereof, as a result of, or in any way connected with Bon Cheval. therapeutic and equine-related programs and activities, ***or growing out of acts or omissions or caused by negligence or in any way incidental to Bon Cheval herapeutic and equine-related programs and activities.*** I have asked, or have had the opportunity to ask, any and all questions that I may have relating to the risks involved in therapeutic and equine-related programs and activities. I fully understand and accept these risks.

Participant if 18 or older		
Name:	**Signature:**	**Date:**
Witness		
Name:	**Signature:**	**Date:**

Parent(s) or Legal Guardian(s) if participant less than 18 years of age		
Name:	**Signature:**	**Date:**

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Witness		
Name:	**Signature:**	**Date:**

If at any time a litigation arises against Bon Cheval by party named as volunteer/legal guardian in this contract is responsible for all legal fees for all said parties.

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Participant Medical History and Physician's Statement

This form is valid for a period of one (1) year from date signed.

Participant Information			
Participant's Name:			
Sex: Male Female	**Date of birth:**	**Height:**	**Weight:**
Street:		**Apt:**	
City:	**State:**	**ZIP Code:**	
Parent/Legal Guardian:			
Diagnosis:		**Date of onset:**	
***For persons with Downs Syndrome** Negative cervical x-ray for Atlantoaxial Instability Date of x-ray: Negative for clinical symptoms of Atlantoaxial Instability			
Tetanus Shot: No Yes **Date**			
Seizure: Type: Controlled: Date of last seizure:			
Medications:			
Mobility: independent ambulation wheelchair cane braces walker crutches special precautions (explain):			

Please indicate if patient has a problem and/or surgery in any of the following and comment.		
Auditory	Yes No	
Visual	Yes No	
Speech	Yes No	

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Cardiac	Yes No	
Circulatory	Yes No	
Pulmonary	Yes No	
Neurological	Yes No	
Muscular	Yes No	
Orthopedic	Yes No	
Allergies	Yes No	
Learning Disability	Yes No	
Mental Impairment	Yes No	
Psychological Impairment	Yes No	
Other	Yes No	

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Psychologist, etc) in the implementing of an effective equestrian program.

Physician name (please print)**:**		
Physician Signature:		**Date:**
Address:		**City:**
Date:	**ZIP Code:**	**Phone:**