



## Returning Participant Application Packet

For us to provide the highest quality service, we require yearly updated information on all participants. Please complete this form to provide us with the most current contact, health and medical information.

Participant's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Diagnosis or Challenge \_\_\_\_\_

Height: \_\_\_\_\_ Weight (required): \_\_\_\_\_ Age: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Caregiver name: \_\_\_\_\_ Phone \_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you or your child currently seeing a specialist or therapist? YES, NO Name: \_\_\_\_\_

Is your child currently on a IEP or 504 plan? YES NO

Participant's updated goals for participating in programs at Swiftsure Ranch:

Goal 1: \_\_\_\_\_

Goal 2: \_\_\_\_\_

Goal 3: \_\_\_\_\_



Changes to medical status in the past year? (Include any hospitalizations, surgeries, seizures, change in medication, changes in medical status, allergies, other):                      Yes              No

Please describe any changes or concerns:

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Parent/guardian if participant is under 18)*

### **Media Waiver**

Participant Name: \_\_\_\_\_

I DO \_\_\_\_\_ or DO NOT \_\_\_\_\_ grant Swiftsure Ranch permission to take and reproduce photographs and video of the above listed participant for the purpose of publication, promotion, advertising, or fundraising. I allow these photos or videos to be used in any manner or medium, including social media.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Parent or guardian if participant is under 18)*



## RELEASE OF LIABILITY

I, the undersigned, for myself and/or on behalf of my child warrant and agree that I will make no claim or file suit for any injury to person or property, or for any loss or destruction of any article of any kind or nature in connection with the participation of me and/or child at the Swiftsure Ranch and/or participation in the programs of the Swiftsure Ranch Therapeutic Equestrian Center. I understand that neither the Swiftsure Ranch nor Swiftsure Ranch Therapeutic Equestrian Center nor their respective officers, directors, employees, volunteers, or agents accept any responsibility for accidents, damage, injury or illness to the riders, horses, members, sponsors, agents, spectators or any other person or property owner in connection with operation of the Swiftsure Ranch. As a condition of using the facilities of the Swiftsure Ranch and the programs of Swiftsure Ranch Therapeutic Equestrian Center, I hereby waive, on my own behalf and/or for my child, all claims arising out of any act or omission of the Swiftsure Ranch and/or Swiftsure Ranch Therapeutic Equestrian Center and their respective officers, directors, employees, volunteers, and agents. I understand that there are inherent risks in any participation and those risks are assumed by me for myself and/or on behalf of my child. I fully understand that animals and conditions are unpredictable and that the risk of injury or death is inherent to the activity of equine-assisted activities and therapies. For myself and/or on behalf of the child, I fully assume the responsibility for the risk of injury or death caused by my and/or the child's contact with horses and horseback riding. I, and/or on behalf of the child, completely release Swiftsure Ranch and Swiftsure Ranch Therapeutic Equestrian Center and their respective officers, directors, employees, volunteers, and agents from any and all liability for any and all injuries or death to either of me and/or to the child caused by my and/or child's contact with horses and/or horseback riding. Signing of this form binds me and/or my child to this hold harmless agreement.  
This document shall be constructed under the laws of the State of Idaho.

Participant's Name: \_\_\_\_\_

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(If participant is under 18)*



**Authorization for Emergency Medical Treatment**

Participant Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Preferred medical facility: \_\_\_\_\_

Health insurance company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Family physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current medications (prescription and over the counter): \_\_\_\_\_

Other pertinent medical information about you or your child in case of an emergency:  
\_\_\_\_\_  
\_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ I CONSENT for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the Swiftsure Ranch property. I authorize Swiftsure Ranch.

Therapeutic Equestrian Center to: (1) Secure and retain medical treatment and transportation if needed, and (2) Release client records upon request to the authorized individual or agency involved in emergency medical treatment. I release the Swiftsure Ranch and Swiftsure Ranch Therapeutic Equestrian Center staff from any and all liability for any decision made in regard to my child's or my injury, care or hospitalization.

\_\_\_\_\_ I DO NOT CONSENT for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the Swiftsure Ranch property.

Parent or guardian MUST always remain on site during equine-assisted activities.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Participant's Consent for Release of Information

I hereby authorize: \_\_\_\_\_  
(physician, therapist, teacher, etc.)

to release information from the records of: \_\_\_\_\_ DOB: \_\_\_\_\_  
(participant's name)

The information is to be released to Swiftsure Ranch Therapeutic Equestrian Center.

For the purpose of developing an equine activity program for the above-named participant, the information to be released is indicated below:

- Medical history
- Physical therapy assessment, evaluation, and program plan
- Speech therapy assessment, evaluation, and program plan
- Mental health diagnosis and treatment plan
- Individual Habilitation Plan (I.H.P.)
- Classroom Individual Education Plan (I.E.P.)
- Psychosocial evaluation, assessment, and program plan
- Cognitive-behavioral management plan
- Other: \_\_\_\_\_

This release is valid indefinitely and can be revoked, in writing, at my request.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or guardian if participant is under 18)

Print Name: \_\_\_\_\_

Relation to Participant: \_\_\_\_\_

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