



**Participant Equine Activity Release**  
**Good Hope Equestrian Training Center**  
***"Where Horses Enrich Lives"***  
(Page 1 of 2)

This Participant Equine Activity Liability Release, Waiver of Right to Sue and Assumption of All Risks Agreement ("the Agreement") is hereby given by \_\_\_\_\_ on his/her own behalf as a participant, AND/OR as the parent or guardian of the above named minor \_\_\_\_\_ who is a participant in or to any program, activity or event taking place under the sponsorship of or at the facilities of Good Hope Equestrian Training Center, Inc. For the purposes of this RELEASE, the term Participant shall include the Participant, his or her heirs, assigns, executors, trustees, personal representatives and administrators.

Equine Activity Sponsor: GOOD HOPE EQUESTRIAN TRAINING CENTER, INC., a Florida not-for-profit corporation (referred to herein as "Sponsor") located at 22155 SW 147<sup>th</sup> Avenue, Miami, Florida. For the purposes of this RELEASE, the term Sponsor shall include the Sponsor, its directors, officers, shareholders, employees, independent contractors, volunteers, agents and Sponsor's subsidiaries and parent entities.

In consideration of the rights, privileges and benefits to me derived from participating in Sponsor's equine activities, which Participant believes outweigh the potential assumed risks, Participant agrees as follows: Participant hereby waives, releases and indemnifies (including all attorneys fees and costs) Sponsor forever from any and all claims of liability that may in the future arise from participating in Sponsor's equine activities, including but not limited to riding, grooming, handling or otherwise interacting with horses, whether on or off Sponsor's premises. The Sponsor shall not be liable for any injuries to, or the death of Participant resulting from the inherent risks of equine activities, and except as provided in Florida Statutes Section 773.03, Participant shall not have any claim against or recover from Sponsor for injury, loss, damage, or death of Participant resulting from any of the inherent risks of equine activities.

**WARNING**

**UNDER FLORIDA LAW, AN EQUINE ACTIVITY SPONSOR OR EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO, OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES. [FLORIDA STATUTE SECTION 773.04 (2)].**

Participants understands that "inherent risks" of equine activities means those dangers which are an integral part of equine activities, including but not limited to: (a) the propensity of equines 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, sounds, sudden movement, and unfamiliar objects, persons on or around them; (c) certain



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hazards such as surface and subsurface conditions; (d) collisions with other equines or objects; (e) the potential of the Participant or other participants to act in a negligent manner that may contribute to injury to the Participant or others, such as failing to maintain control over the animal or not acting within his or her ability.

Participant represents that Participant has the sufficient skills and ability to safely manage the particular equine activities, in which Participant has now, or may in the future voluntarily, chose to participate. This RELEASE shall cover all incidents arising at anytime throughout the duration of the equine activities, and shall remain in full force and effect from the date of this RELEASE forever.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Participant

I acknowledge that I am of legal age and capacity to enter into this RELEASE.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

### **PHOTO RELEASE**

Further, Participant consents to and authorizes the reproduction and use by Sponsor of any and all photographs and any other audio-visual materials taken of Participants for promotional materials, new publications, educational activities, exhibitions or for any other use for the benefit of the program.

I have read and understand this RELEASE and voluntarily agree to be legally bound to its terms and conditions.

\_\_\_\_\_  
Participant

I acknowledge that I am of legal age and capacity to enter into this RELEASE.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Signature of Sponsor



**Participant Authorization for  
Emergency Medical Treatment Form**  
*"Where Horses Enrich Lives"*

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Physician's Name: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_  
 Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
 Allergies to medications: \_\_\_\_\_  
 Current Medications: \_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize **Good Hope Equestrian Training Center, 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 medical emergency treatment.

**Consent Plan**

This authorization includes x-ray, surgery, 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.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_  
 Client, Parent, or Legal Guardian

**Non-Consent Plan**

I do not give 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 of legal guardian will remain on site at all times during equine assisted activities
- In the event emergency treatment/aid is required, I wish the following procedure to take place:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_  
 Client, Parent or Legal Guardian



## PHYSICIAN'S STATEMENT

### Good Hope Equestrian Training Center

Past prospective surgeries: \_\_\_\_\_  
 Medications: \_\_\_\_\_  
 Seizure Type: \_\_\_\_\_ Controlled: Y N Date of Last Seizure: \_\_\_\_\_  
 Shunt Present: Y N Date of last revision: \_\_\_\_\_  
 Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N  
 Braces/Assistive Devices: \_\_\_\_\_  
**For those with Down Syndrome:** AtlantoDens Interval X-rays date: \_\_\_\_\_ Result: + -  
 Neurologic Symptoms of AtlantoAxial Instability: \_\_\_\_\_

*Please indicate current or past special needs in the following systems/areas, including surgeries:*

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

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Name/Title: _____ MD DO NP PA Other _____
Physician's Signature: _____ Date: _____
Address: _____
Phone: ( ) _____ License/UPIN Number: _____

22155 South West 147<sup>th</sup> Avenue, Miami, Florida 33170 Phone: (305) 258-2838 Fax: (305) 258-2902



**PHYSICIAN'S STATEMENT**

**Good Hope Equestrian Training Center**

Dear Health Care Provider:

Your patient \_\_\_\_\_ is interested in participating in supervised equine activities.

*Participant's name*

In order to safely provide this service, our center requested 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. 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 below.

**Orthopedic**

- Atlantoaxial Instability – include neurologic symptoms
- Coxa Arthrosis
- Cranial Deficits
- Heterotopic Ossification
- Joint subluxation/dislocation
- Osteoporosis
- Pathological fractures
- Spinal Joint Fusion/Fixation
- Spinal Joint Instability
- Abnormalities
- Amputee

**Medical/Psychological**

- Allergies
- Animal Abuse
- Cardiac Condition
- Fire Settings
- Blood Pressure Control
- Dangerous to self or others
- Exacerbations of medical condition (i.e.: RA, MS)
- Fire Settings
- Hemophilia
- Medical Instability
- Migraines
- PVD
- Respiratory Compromise
- Recent Surgeries
- Substance Abuse
- Thought Control Disorders
- Physical/Sexual/Emotional Abuse

**Neurologic**

- Hydrocephalus/shunt
- Seizure
- Spina Bifida/Chiari II malformation/Thethered Cord/Hydromyelia
- Traumatic Brain Injury

**Other**

- Age – Under 3 years
- Indwelling Catheters
- Medical Equipment
- Medications – i.e. photosensitivity
- Poor Endurance
- Skin Breakdown
- Post Traumatic Stress Disorder

Physician's Notes/Comments:

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Physician's Signature \_\_\_\_\_

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





## **Rider Rules & Regulation Form**

1. Name of Client: \_\_\_\_\_

2. Name of Parent: \_\_\_\_\_

3. Home Address: \_\_\_\_\_

4. Contact Numbers:

Home: \_\_\_\_\_

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

5. E-Mail Address: \_\_\_\_\_

6. Physician's Name: \_\_\_\_\_

7. Physician's Phone number: \_\_\_\_\_

8. Physician's Fax number: \_\_\_\_\_

9. Allergies: \_\_\_\_\_

10. Precautions: \_\_\_\_\_

1. All equine assisted activities participants must arrive at least ten minutes prior to their session, so the GHETC staff members can fit their helmet and get them prepared for the appointment.
2. There is a \$40.00 fee for each group equine assisted activity session or \$40.00 for a half hour private session & \$60.00 for an hour private session. Please pay for services on a monthly basis prior to services rendered. All checks must be made payable to: Good Hope Equestrian Training Center.
3. Parents & siblings are not permitted within the stable without the presence of a Good Hope staff member.
4. Regardless of inclement weather, we will personally call you if we are canceling the session. As you know, it may be raining at your house; whereas it is sunny and beautiful at Good Hope.



5. All parents and siblings must be quiet during therapeutic riding sessions. Horses can become spooked with sudden movements and sounds, so for safety reasons for everyone involved this rule must be followed. This means no running around, playing on the ramp, talking or standing close to the ring. You are more than welcome to watch the class from a distance (in clubhouse or standing away from the sand or grass ring).
6. There is a twenty-four hour cancellation policy in which you must call or you will be charged for the session. Please call the main office and the instructors, Peggy Bass or Stephanie Strand when and if you need to cancel your appointment.  
Good Hope office: (305) 258-2838  
Peggy Bass: (305) 297 - 4729  
Stephanie Strand : (786) 247 -6656
7. If you miss more than two consecutive scheduled appointments your time slot will be given to another individual and there is a chance you will have to go on a waiting list.

Name of Participant:

\_\_\_\_\_

Printed Name of Guardian:

\_\_\_\_\_

Signature of  
Guardian:\_\_\_\_\_

E-Mail Address:

\_\_\_\_\_

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

Emergency Contact numbers:\_\_\_\_\_

\_\_\_\_\_