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**For LoveWay use**

Received by \_\_\_\_\_ Date \_\_\_\_\_

Terms taken:

\_\_\_\_\_  
\_\_\_\_\_

## Community Outreach & Leadership for Teens

### COLT PROGRAM APPLICATION

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Birth Date (mm/dd/yy) \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

E-mail \_\_\_\_\_ T-Shirt Size: S  M  L  XL  XXL

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

School \_\_\_\_\_ High school graduation year \_\_\_\_\_

Preferred method(s) of communication: Cell call  Text  E-mail  Home  Work

How did you hear about the COLT program? Friend/Family member  Internet search  Facebook   
Newspaper  Radio  TV  Other: \_\_\_\_\_

Languages spoken other than English \_\_\_\_\_

School clubs, sports, other activities \_\_\_\_\_

Any previous volunteer experiences \_\_\_\_\_

Any previous horse experience \_\_\_\_\_

Any previous experience with people with special needs \_\_\_\_\_

Why does this program interest you?

What skills, experiences or insights do you hope to receive through participating?

What are your interests and passions?

What are your plans and dreams for after high school?

**\*\*Please continue and complete the next side\*\***

Allergies \_\_\_\_\_

Medications \_\_\_\_\_

Describe any physical/health limitations \_\_\_\_\_

### **Authorization for Emergency Medical Treatment**

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Hospital: Goshen Health Hospital  Elkhart General Hospital

In case of an emergency, **I consent**  <or> **I do not consent**  for LoveWay to secure medical treatment including x-rays, surgery, hospitalization, transportation and medication as recommended by the attending emergency medical personnel.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

*Must be Parent/Legal Guardian signature if under 18 years of age*

### **Confidentiality Policy**

LoveWay, Inc. staff and volunteers will protect the rights and confidentiality of all participants. Medical and personal information regarding participants will be shared with volunteers only for the purpose of providing safe and effective services. No information regarding a participant is to be shared with others outside of the therapeutic environment at LoveWay, Inc. Discovery of such disclosure may result in the termination of said volunteer. I hereby agree to abide by the above stated confidentiality policy.

### **Photo & Media Release**

**I Consent**  **OR I Do Not Consent**  to the use of any and all promotional, educational, or program photos, videos, or other audio-visual materials of myself while participating at the facility or engaged in an authorized LoveWay activity for promotional material, educational activities, exhibitions, website, or any other use for the benefit of the program.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

*Must be Parent/Legal Guardian signature if under 18 years of age*

### **Waiver Agreement & Liability Release**

My signature below denotes that I agree to all the following as a condition for myself/child/family as it pertains to LoveWay, Inc. (hereafter referred to as the "Center") as a condition for participation in activities at/on/near the Center's premises and property or associated with any Center activity including but not limited to equine-assisted activities, trail riding, arena instruction, barn & pasture activities, demonstrations and public events. **Under Indiana law, an 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.** As the legal representative of the participant (myself/child/family) I acknowledge the risks and potential for risks of equine related activities. I understand not all risks can be foreseen nor prevented. I understand these risks and assume responsibility for them. **I hereby, intending to be legally bound for myself/child/family, heirs and assigns, executors or administrators, waive and release forever all claims for damages (present or future) against LoveWay, Inc., its Board of Directors, Executive Director, Instructors, Staff, Therapists, Volunteers and/or other authorized persons for any and all injuries/losses sustained while participating or visiting at LoveWay, Inc.** As consideration for the Center to allow myself/child/spouse/family members to engage in Center related activities, I agree to assume full responsibility for any and all bodily injuries, losses, or damages, which I or they might sustain.

It is mutually understood and agreed that the waiver and liability release set forth in this document constitutes a waiver of liability beyond the provisions of the Indiana Equine Activity Liability Act. I further agree to indemnify and hold harmless the Center or persons/entities associated with the Center and to not bring any claim or suit against them on the basis of any exception to the IN Equine Act. Should I breach any part of this waiver/liability release, I agree to pay all the Center's attorney's fees or other legal costs that may occur.

I attest that I am at least 18 years of age, of sound mind, not suffering from shock or under the influence of alcohol, drugs or intoxicants. I have read this ENTIRE waiver and application and fully understand it. I intend for this waiver, agreement and liability release to be valid and binding today and at ALL FUTURE TIMES. I attest that all the information I have provided in this application/medical history is true and accurate. My signature denotes agreement with ALL the information on both sides of this form.

**Your signature denotes agreement to abide by the above policies and information.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

*Must be Parent/Legal Guardian signature if under 18 years of age*

**Please return this completed form to the LoveWay office**