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2025/2026 Participant Application

Updated 1/29/2025

Participant Info

Participant's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

School: _____ Ethnicity: _____

Age: _____ Height: _____ Weight: _____ Gender: _____

Legal Representative Info

Legal Representative Name: _____

Address (If different from participant): _____

Email: _____ Phone: _____

Place of Employment: _____ Work Phone: _____

I am the: ☐ Parent ☐ Guardian ☐ Case Manager ☐ Other: _____

- *If not the participant's parent, proof of legal representation is required.*

Health History

Diagnosis/Disability: _____

Does the participant have a current behavior plan? ☐ No ☐ Yes (please provide a copy)

Does the participant have any of the following health conditions?

☐ Abusive/violent behaviors ☐ Orthopedic restrictions ☐ Braces/prosthetics ☐ G-Tube

☐ Weakness in the extremities ☐ High blood pressure ☐ Hearing impairment ☐ Respiratory condition

☐ Weight lifting restrictions ☐ Heart condition ☐ Vision impairment ☐ Seizures

☐ Allergies: _____

Current Medications (Including over the counter meds): _____

_____

Describe the participant's disabilities in the following areas and include assistance or equipment needs:

- Function (Example: mobility skills, walking, motor skills, holding objects, communication, speech)

_____

_____

- Social (Example: difficulty relating to others, aggressive behaviors, fearful)

_____

_____

Seizure Questionnaire

History of Seizures? ☐ Yes ☐ No (If no, please sign below and continue to page 3)

Date of Last Seizure: _____ Seizure Type: _____

When were they diagnosed with seizures? _____

How often do they have a seizure? _____

How long does the seizure last? _____

Are they on medication to help with the seizures? ☐ No ☐ Yes

If yes, please explain: _____

Is there any pre-seizure behavior? ☐ No ☐ Yes

If yes, please explain: _____

Is there a typical motor activity during seizures? ☐ No ☐ Yes

If yes, please explain: _____

Is there any post-seizure behavior? ☐ No ☐ Yes

If yes, please explain: _____

What steps should the school teacher/paraprofessional take in the event a seizure should occur at our facility?

_____

_____

I attest that all information on pages 1 and 2 is true and accurate.

Legal Representative Signature: _____

Emergency Contacts

In case we are unable to reach you in an emergency, please list who we can contact after you.
Please include at least one person who does not live in your house.

Name & Relation to Participant: _____ Phone: _____

Name & Relation to Participant: _____ Phone: _____

Physician: _____ Phone: _____

Registered Nurse Assessment Agreement

The Registered Nurse Form is provided as an option for those who may not be able to have a doctor fill out the full Physician Form at this time. By having a Registered Nurse Form filled out by the participant's school nurse, this can potentially allow them to participate in unmounted services.

As we want to ensure the safety of all involved, along with following the policies set by PATH International and Certified Horsemanship Association, please be aware of the following conditions:

1) A complete Participant Application filled out by the participant's legal representative is still required.
2) Participants approved through the Registered Nurse Form are able to participate in unmounted activities only.
3) This form is not applicable for those with a down syndrome diagnosis. A Physician Form is required in those instances.

If needed, I approve for a Registered Nurse from the participant's school to complete the Registered Nurse Form in place of the Physician Form and attest I am the legal representative of the participant.

☐ I consent ☐ I do NOT consent Legal Representative Signature: _____

Authorization for Emergency Medical Treatment

In case of an emergency LoveWay is authorized to secure emergency medical treatment including but not limited to: x-rays, surgery, hospitalization, and medication as recommended by the attending emergency medical personnel. I also agree to the release of any medical records necessary for the timely treatment of a medical emergency.

Consent is required to participate in LoveWay services.

☐ I consent ☐ I do NOT consent Legal Representative Signature: _____

Preferred Hospital: ☐ Goshen Health Hospital ☐ Elkhart General Hospital ☐ Other: _____

Health Insurance & Policy Number: _____

Medication Allergies: _____

Photo & Media Release

LoveWay, Inc. and/or the local media may use any photos or videos taken of myself/participant/family members during LoveWay, Inc. related activities for promotional, educational, or program use. This may include celebrating the participant's achievements and milestones on our social media platforms by using their first name and their milestone achieved. We deeply value your privacy and are committed to protecting the participant's personal information. All stories will be handled with the utmost care, respect, and sensitivity.

☐ I consent ☐ I do NOT consent Legal Representative Signature: _____

Waiver Agreement & Liability Release

My signature below denotes that I agree to all the following as a condition for myself, my children, and my 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. **WARNING: 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, my children and my family, heirs and assigns, executors or administrators, waive and release forever all claims, liabilities and damages (present or future) against LoveWay, Inc., its Board of Directors, Executive Director, Instructors, Staff, Volunteers, Agents and/or other authorized persons for any and all injuries/losses sustained, directly or indirectly while participating and/or visiting at LoveWay, Inc.** As consideration for the Center to allow myself, my children, my spouse and my family members to engage in Center related activities, I agree to assume full responsibility for any and all bodily injuries, losses, claims, liabilities, 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 of 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.

Legal Representative Signature: _____ Date: _____

Legal Representative Printed Name: _____