WINGS OF EAGLES RANCH

4800 Faith Trails ♦ Concord, NC 28025 ♦ (704)784-3147
www.wingsofeaglesranch.org

RIDER'S APPLICATION AND HEALTH HISTORY

GENERAL INFORMATION **DATE:** _____

How did you hear about our program? _____

Participants First Name: _____ Last: _____

Parent/Guardian: _____

Phone (home):_____

Mom (cell):_____ Dad (cell):_____

Address_____ City_____ State_____ Zip_____

E-mail:_____

Disability: _____Birthdate:_____/_____/_____

Age: _____ Height: _____Weight: _____ M or F

For grant purposes only (We appreciate your help with this information)

Ethnicity: ☐African American ☐ Asian ☐Caucasian ☐Hispanic ☐Native American ☐Other_____

Place of Employment: Husband: _____Wife:_____

County: ☐Cabarrus ☐Rowan ☐Stanley ☐Mecklenburg ☐Union ☐Iredell

HEALTH HISTORY - ***Please indicate current or past problems in the following areas:***

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Emotional			
Circulation			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

RIDER'S APPLICATION AND HEALTH HISTORY…CONTINUED

What medications are you currently taking, including over-the-counter medications?

_____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

FUNCTION (i.e., Mobility skills such as transfers, walking, wheelchair use, and driving/bus riding)

SOCIAL (i.e., work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

GOALS: (i.e., What would you like for your child to accomplish?)

Wings of Eagles Ranch

Authorization for Emergency Medical Treatment

Rider's Name: _____

Parent's Name:_____

Address: _____City: _____Zip: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Physician's Name:_____ Medical Facility:_____

Health Insurance Company:_____ Policy #:_____

Allergies to Medications:_____

Current Medications:_____

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 Wings of Eagles Ranch 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 my 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. In the event emergency treatment/aid is required, I wish the following procedures to take place:

✓**Date: ____/____/____ Consent Signature:_____**

Client, Parent, or Legal Guardian

Wings of Eagles Ranch

4800 Faith Trails, Concord, NC 28025

RELEASE AND INDEMNIFICATION AGREEMENT

STATE OF NORTH CAROLINA §
§ KNOW ALL MEN BY THESE PRESENTS:
COUNTY OF CABARRUS §

THAT for and in consideration of the undersigned being permitted on and at the WINGS OF EAGLES RANCH a North Carolina non-profit corporation, (hereinafter the "Ranch") situated in Cabarrus County, North Carolina, for the purpose of engaging in equine activities as that term is defined in NC ST § 99E-1(1) and NC ST § 99E-1(3), the undersigned agrees that he/she shall engage in equine activities at his/her own risk and accepts the inherent risks of equine activities or other activities thereon including, but not limited to, running, biking, zip line, climbing, skeet shooting, water related activities at the pond, swimming pool, high and low rope activities, overnight stays or other activity thereon, the undersigned agrees that he shall enter onto the Ranch property at his/her own risk and accepts such Ranch property in its present condition and CHRISTINE CRONIN, Wings of Eagles Ranch, their spouses, agents, employees, heirs, executors, administrators, the Board of Directors, volunteers, successors and assigns, jointly and severally (herein collectively "Releasees") shall not be liable to the undersigned or to the spouses, heirs, agents, employees, servants, guests, invitees or assigns of the undersigned for damages or personal injuries which may arise out of the undersigned venturing upon the Ranch property for the purpose of activities thereon including, but not limited to, equine activities, running, biking, zip line, climbing, skeet shooting, water related activities at the pond, swimming pool, high and low rope activities, overnight stays or other activity thereon, or in using or exercising any rights, privileges and benefits extended by Releasees to the undersigned on or about the Ranch or Ranch property (whether such damages or personal injuries are caused by natural or un-natural conditions existing on the Ranch property and whether such damages or personal injuries, including disease, are caused by man, beast, fowl, insects, reptiles and other animals, including but not limited to wild pigs, bobcats, horses, deer, dogs, cats, skunks, squirrels, ticks, fleas, snakes, and Acts of God i.e. weather and tree falls or other animals or insects) and **the undersigned represents that he has inspected the Ranch and Ranch property and accepts entry thereon in its present condition and agrees to RELEASE, ACQUIT, HOLD HARMLESS and FOREVER DISCHARGE Releasees, their spouses, agents, servants and employees and all persons, natural or corporate, in privity with them or any of them, from any and all claims or causes of action of any kind whatsoever, including claims and damages arising in whole or in part from the negligence of Releasees whether that negligence is the sole or contributory cause of the resultant injury, death or damage, at common law, statutory or otherwise, which the undersigned has or might have, known or unknown, now existing or that might arise hereafter, directly or indirectly attributable to the use and occupancy of the Ranch for the purpose of any and all activities, and the undersigned further agrees to INDEMNIFY AND HOLD RELEASEES HARMLESS FROM AND AGAINST ANY AND ALL SUITS, ACTIONS, LOSSES, DAMAGES, CLAIMS, OR LIABILITY OF ANY CHARACTER, TYPE, OR DESCRIPTION, INCLUDING ALL EXPENSES OF LITIGATIONS, COURT COSTS, AND ATTORNEY'S FEES FOR INJURY OR DEATH TO ANY PERSON OR INJURY TO ANY PROPERTY, RECEIVED OR SUSTAINED BY ANY PERSON OR PERSONS OR PROPERTY, ARISING OUT OF OR OCCASIONED BY, DIRECTLY OR INDIRECTLY, THE UNDERSIGNED VENTURING UPON THE RANCH FOR THE PURPOSE OF ANY AND ALL ACTIVITIES THEREON, INCLUDING CLAIMS AND DAMAGES ARISING IN WHOLE OR IN PART FROM THE NEGLIGENCE OF RELEASEES. IT IS THE EXPRESS INTENT OF THE PARTIES TO THIS AGREEMENT THAT THE INDEMNITY PROVIDED FOR HEREIN IS AN INDEMNITY EXTENDED BY THE UNDERSIGNED TO INDEMNIFY AND PROTECT RELEASEES FROM THE CONSEQUENCES OF RELEASEES "OWN NEGLIGENCE" WHETHER THAT NEGLIGENCE IS THE SOLE OR CONTRIBUTORY CAUSE OF THE RESULTANT INJURY, DEATH, OR DAMAGE.**

The undersigned further agrees to defend, at his own expense, and on behalf of Releasees, and in the name of Releasees, any claim or litigation brought in connection with any such injury, death or damage, except that Releasees shall be entitled to select their respective counsel, however, the cost for such defense shall be paid for solely by the undersigned.

This Release and Indemnification Agreement and all contents herein, are expressly made binding upon and shall inure to the detriment of the heirs, legal representatives, administrators, executors, appointees, legatees, devisees, trustees, successors and assigns of each of the undersigned hereto, and their children, wards or issue.

WARNING

UNDER NORTH CAROLINA 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 EXCLUSIVELY FROM THE INHERENT RISKS OF EQUINE ACTIVITIES. CHAPTER 99E OF THE NORTH CAROLINA GENERAL STATUTES.

I understand and will abide by any and all Ranch Rules.

Photo Release:

I ☐ DO

I ☐ DO NOT

Consent to and authorize the use and reproduction by Wings of Eagles Ranch of any and all photographs and any other audio/visual materials taken for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

Executed the _____ day of _____, 20_____.

Rider/Volunteer/Guest Name: _____

✓**Signed: _____ Driver's License # _____**

(If under 18, Parent or Legal Guardian)

WINGS OF EAGLES RANCH

4800 Faith Trails ♦ Concord, NC 28025 ♦ (704)784-3147
www.wingsofeaglesranch.org

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

(To be filled out by Rider's Physician)

Date:_____

Participant: _____ DOB: _____ Height: _____Weight_____

Address: _____ City:_____ Zip:_____

Diagnosis: _____Date of Onset: _____

Past/ProspectiveSurgeries:_____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure:_____

- **Shunt Present**: Y N Date of last revision: _____
- **Special Precautions/Needs**: _____

  Mobility: Independent Ambulation: □ Y □ N Assisted Ambulation: □ Y □ NWheelchair: □ Y □ N

Braces/Assistive Devices: _____

Tetanus Shot: □ Yes □ No

For Those with Down syndrome: **Atlantoaxial Instability (AAI) X** -rays, date: _____ Result: ☐ + or ☐

Please indicate current or past difficulties in the following systems/areas, including surgeries:

Areas	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			

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, Speech, Psychologist, etc.) in the implementation of an effective equestrian program.

Name/Title (MD, DO, NP, Other): _____ Phone:_____

Signature: _____Date: _____ License/UPINNumber: _____