



HORSES FOR HEROES
WILD HEARTS THERAPEUTIC EQUESTRIAN PROGRAM

Wild Hearts Horses for Heroes Participant Application		
(First)	(Middle)	(Last)
Complete Legal Name:		
Nickname:	Date of Birth:	Gender:
Please circle the best way for Wild Hearts staff to reach you:		
Home Phone: ()	Cell Phone: ()	Work Phone: ()
Home email:	Work email:	
Mailing Address:		
City:	State:	Zip:
Please indicate experience working with horses (no prior experience required):		
Referral Information		
How did you hear about the program? <input type="checkbox"/> Website <input type="checkbox"/> Media <input type="checkbox"/> Referral _____ <input type="checkbox"/> Other _____		
Referring Physician/Agency/Clinic: _____		
Contact Name: _____ Telephone: _____		
Military Service		
Please circle whether you are: Active / Discharged / Retired		
Please indicate the branch in which you served: _____		

Emergency Contact

Primary Contact Name:	Relationship:	Phone: ()
Address:		
Secondary Contact Name:	Relationship:	Phone: ()

Personal Disclosure

To help us provide you with a safe experience,
 please complete with the information you feel comfortable disclosing

Diagnosis:

Medications: Tetanus Shot: Y N

Mobility: Independent Ambulation Y N Assisted Ambulation Y N
(Please note that participants must be ambulatory to enroll in Wild Hearts Horses for Heroes program)

Special Precautions/Needs:

Please indicate current and past special needs in the following system/areas:

<u>AREAS</u>	<u>Yes</u>	<u>No</u>	<u>Comments</u>
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological (including seizures)			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			

Photo Release

I DO / DO NOT (**please circle one**) consent to and authorize the use and reproduction by Wild Hearts Therapeutic Equestrian Program, Inc. of any and all photographs and any other audio/visual materials taken of me or my family member for promotional materials, educational activities, exhibitions or for any other use for the benefit of Wild Hearts Therapeutic Equestrian Program.

Signature _____ Date _____

Liability Release

I, _____, the undersigned adult, as client/participant would like to participate at Wild Hearts Therapeutic Equestrian Program, Inc.

I acknowledge the risk and potential for risks of equine activities. I understand that I will be working with and around horses. However, I feel that the possible benefits to myself are greater than the risk assumed. I, the undersigned client/participant, hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrator, waive and forever release, acquit, discharge and hold harmless all claims for damages against Wild Hearts Therapeutic Equestrian Program, Inc., its board of directors, trustees, agents, instructors, therapists, employees, representatives, volunteers, owners of property on which Wild Hearts Therapeutic Equestrian Program, Inc. operates, successors or assigns on account of any personal injuries and/or personal damages known or unknown, or in any way growing out of, the acts of Wild Hearts Therapeutic Equestrian Program, its board of directors, trustees, agents, instructors, therapists, employees, representatives, volunteers, owners of the property on which Wild Hearts Therapeutic Equestrian Program, Inc. operates, successors or assigns.

I understand that **UNDER MASSACHUSETTS 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 ACTICITIES, PURSUANT TO SECTION 2D OF CHAPTER 128 OF THE GENERAL LAWS.**

Client/Participant Signature _____ Date _____

COVID-19 Vaccination

In order to provide a safe environment for all at Wild Hearts, we require proof of vaccination for all staff, volunteers and participants. Please provide a copy of your vaccination card. Thank you!