



## Participant Application and Health History

To be completed by the participant or parent/legal guardian/caregiver

Participant Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: \_\_\_\_\_

Current Residential Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_ Alternate Phone (specify): \_\_\_\_\_

Employer/School: \_\_\_\_\_ Occupation: \_\_\_\_\_

Parent/Legal Guardian/Caregiver 1: \_\_\_\_\_ Occupation: \_\_\_\_\_

Parent/Legal Guardian/Caregiver 2: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Phone (if different from above): \_\_\_\_\_

How did you hear about the program? \_\_\_\_\_

### Health History

Diagnosis: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_

Please indicate current or past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Cognitive			
Allergies			

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Or, email: Karen Brittle at karen.brittle@centenaryuniversity.edu



**Health History, cont.**

**MEDICATIONS** (include prescription, over-the-counter with name, dose and frequency)

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**PHYSICAL FUNCTION** (i.e. Mobility skills such as transfers, walking wheelchair use driving, bus riding, etc.)

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**COMMUNICATION** (i.e. Describe speech/language diagnosis, therapies and any social-pragmatic problems)

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**GOALS** (i.e. Why are you applying for participation? What would you like to accomplish?)

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**Provide any additional information** you feel it is important for us to know (i.e. work/school including grade completed, leisure interests, relationships, family structure, support systems, companion animals, fears/concerns about participating, etc.).

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## PHOTO/VIDEO PERMISSION

### EDUCATIONAL PHOTOGRAPHY RELEASE (**Mandatory**)

I hereby consent to allow Therapeutic Riding At Centenary/Centenary University to use photographs and/or videos of me/my child *exclusively* for the purpose of educating Centenary University student instructors. I understand that these will not be used for any promotional purpose without my written permission.

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

Date \_\_\_\_\_

### PROMOTIONAL PHOTOGRAPHY RELEASE (**Optional**)

- I do
- I do NOT

consent to allow Therapeutic Riding At Centenary/Centenary University to use photographs and/or videos of me/my child for any purpose, and in any manner without limitation, including for print media, television, exhibition, publication, social media and any trade or advertising purpose. I understand that these photographs/videos may be used in promotional materials, electronic and print publications, and other uses of benefit to the TRAC program/Centenary University.

Participant Name: \_\_\_\_\_

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

(Parent/Legal Guardian if under 18 or adult where legal guardianship applies)



**RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK AND IDEMNITY AGREEMENT**

I, \_\_\_\_\_ (“Participant”), hereby acknowledge that I have voluntarily elected to participate in the \_\_\_\_\_ Equine Activities \_\_\_\_\_ (“Program/Activity”), to be held in and around \_\_\_\_\_ The Centenary Equestrian Center \_\_\_\_\_ (location), from \_\_\_\_\_ (insert date(s)). **In consideration for being permitted by Centenary University to participate in the Program/Activity, I hereby acknowledge and agree to the following:**

**ELECTIVE PARTICIPATION:** I acknowledge that my participation is elective and voluntary and that my participation is not required by the University.

**RULES AND REQUIREMENTS:** I agree to conduct myself in accordance with Centenary University’s policies and procedures. I further agree to abide by all the rules and requirements of the Program/Activity. I acknowledge that the University has the right to terminate my participation in the Program/Activity if it is determined that my conduct is detrimental to the best interests of the group, my conduct violates any rule of the Program/Activity, or for any other reason in the University’s discretion.

**INFORMED CONSENT:** I have been informed of and I understand the various aspects of the Program/Activity, including but not limited to traveling to and from Program/Activity site via private vehicle, common carrier, and/or University owned vehicle, behavior of the equine animals, conditions of facilities, injuries due to conditions of equipment, weather conditions, wildlife, negligent first aid operations, and there may be other risks not known to me or not reasonably foreseeable to me at this time. In addition, I understand that as a participant in the Program/Activity events, I will engage in physical activities, riding, competing, practicing, training, observing, and competing in Program/Activity events, during which I could sustain serious personal injuries, illness (including communicable diseases), property damage, or even death as a consequence of not only Centenary University’s actions or inactions but also the actions, inactions, negligence or fault of others, conditions of the equipment used, facility conditions, weather conditions, negligent first aid operations and procedures and I understand that there may be other risks not known to me or not reasonably foreseeable at this time. I further understand and agree that any injury, illness (including communicable diseases), property damage, disability, or death that I may sustain by any means is my sole responsibility except for those occurrences due to the CENTENARY University’s negligence or intentional acts.

**RELEASE AND WAIVER OF LIABILITY:** I, on behalf of myself, my personal representatives, heirs, executors, administrators, agents, and assigns, HEREBY RELEASE, WAIVE, DISCHARGE, AND COVENANT NOT TO SUE Centenary University, Its governing board, directors, officers, employers, agents, volunteers, and any students (hereinafter referred to as “Releases”) for any and all liability, including any and all claims, demands, causes of action (known or unknown), suits, or judgements of any and every kind (including attorneys’ fees), arising from any injury, illness (including communicable diseases), property damage or death that I may suffer as a result of my own negligent acts.

**ASSUMPTION OF RISK:** Under New Jersey law, a participant and spectator are deemed to assume the inherent risks of equine animal activities created by equine animals, weather conditions, conditions of trails, riding rings, training tracks, equestrians, and all other inherent conditions. Each participant is assumed to know the range of his or her ability and it shall be the duty of each participant to conduct himself or herself within the limits of such ability to maintain control of the equine animal and to refrain from acting in a manner which may cause or contribute to the injury of the participant or others, loss or damage to person or property, or death which results from the participation in an equine animal activity. **WARNING: UNDER NEW JERSEY LAW, AN EQUESTRIAN AREA OPERATOR IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ANIMAL ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ANIMAL ACTIVITIES, PURSUANT TO P.L. 1997, c.287 (C:5:15-1 et seq.) (“New Jersey Equestrian Law”).**

I understand that there are potential dangers incidental to my participation in the Program/Activity, some of which may be dangerous and which may expose me to the risk of personal injuries, property damage, or even death. I understand that these potential risks are including but not limited to activities such as, riding, practicing, training, competing, observing, traveling to and from Program/Activity site via private vehicle, common carrier, and/or University owner vehicle, injuries due to the behavior of the equine animals, condition of equipment, weather conditions, facility conditions, wildlife, negligent first aid operations of Releases, and other risks that are unknown at this time.

In addition, I understand that there are risks attendant to physical activities and that there are potential dangers which may expose me to the risk of personal injuries, property damage, or even death. I am aware that the Program/Activity can be a vigorous activity involving severe cardiovascular stress and/or violent physical contact. I understand that Program/Activity activities involve certain risks, \_\_\_\_\_ INITIAL

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including but not limited to, death, serious neck and spinal injuries resulting in complete or partial paralysis, brain damages, and serious injury to virtually all bones, joints, muscles, and internal organs, and that protective equipment may be inadequate to prevent serious injury.

I further understand that Program/Activity involves a particularly high risk of knee, head, and neck injury. In addition, I understand that participation in the Program/Activity involves activities incidental thereto, including, but not limited to, travel to and from the site of the activity, participation at sites that may be remote from available medical assistance, and the possible reckless conduct of other participants. I understand that these potential risks include, but are not limited to; travel to and from Centenary University, via private vehicles, common carriers, and/or Centenary University owned vehicles, or local transportation, behavior of the equine animals, weather conditions, facility conditions, equipment conditions, negligent first aid operations or procedures of Releases, and other risks that are unknown at this time. I KNOWINGLY AND VOLUNTARILY ASSUME ALL SUCH RISKS, BOTH KNOWN AND UNKNOWN, and assume full responsibility for my participation in the Program/Activity.

**INDEMNITY:** I, on behalf of myself, my personal representatives, heirs, executors, administrators, agents, and assigns, agree to hold harmless, defend and indemnify the Releases from any and all liability, including any and all claims; demands, causes of action (known or unknown), suits, or judgements of any and every kind (including attorneys' fees), arising from any injury, property damage or death that I may suffer as a result of my participation in the Program/Activity, except to the extent the Releasee is liable under the New Jersey Equine Law.

**PERSONAL MEDICAL INSURANCE:** I agree to purchase and maintain during the term of the Program/Activity personal medical insurance. I further acknowledge that I am responsible for the cost of any and all medical and health services I may require as a result of participating in the Program/Activity.

**CERTIFICATION OF FITNESS TO PARTICIPATE:** I attest that I am physically and mentally fit to participate in the Program/Activity and I do not have any medical record of history that could be aggravated by my participation in my particular sport

**MEDICAL CONSENT:** I understand and agree that the Releases may not have medical personnel available at the location of the Program/Activity. In the event of any medical emergency, I authorize and consent to the University contacting emergency and/or medical personnel and to any x-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment, and hospital care that may be deemed necessary for my safety and protection. I understand and agree that Releases assume no responsibility for any injury or damage which might arise out of or in connection with such authorized emergency medical treatment.

**CHOICE OF LAW:** I hereby agree that this Agreement shall be construed in accordance with the laws of the State of New Jersey.

**SEVERABILITY:** If any term or provision of this Agreement shall be held illegal, unenforceable, or in conflict with any law governing this Agreement the validity of the remaining portions shall not be affected thereby.

I HAVE READ THIS AGREEMENT AND FULLY UNDERSTAND ITS TERMS. I AM AWARE THAT THIS AGREEMENT INCLUDES A RELEASE AND WAIVER OF LIABILITY, AND ASSUMPTION OF RISK, AND AN AGREEMENT TO INDEMNIFY THE RELEASEES. I UNDERSTAND I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING THIS AGREEMENT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT. BY MY SIGNATURE I REPRESENT THAT I AM AT LEAST EIGHTEEN YEARS OF AGE OR, IF NOT, THAT I HAVE THE SIGNATURE OF MY PARENT OR GUARDIAN AS WELL AS MY OWN.

\_\_\_\_\_  
**SIGNATURE OF PARTICIPANT** **DATE**

**Signature of Parent/Guardian for Participants under eighteen (18) years of age:**

I certify that I have custody of participant or am the legal guardian of Participant by court order and give permission for participation. I HAVE READ THIS AGREEMENT AND FULLY UNDERSTAND ITS TERMS. I AM AWARE THAT THIS AGREEMENT INCLUDES A RELEASE AND WAIVER OF LIABILITY, AN ASSUMPTION OF RISK, AND AN AGREEMENT TO INDEMNIFY THE RELEASEES. I join with Participant in executing this document and agree to be legally bound.

\_\_\_\_\_  
**SIGNATURE OF PARTICIPANT** **DATE**

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**WAIVER OF LIABILITY, ASSUMPTION OF RISK AND RELEASE**

**EQUESTRIAN ACTIVITIES**

In consideration of being permitted to participate in the following activities of Centenary University: working or shadowing in the vicinity of and/or with horse(s) and in full recognition and appreciation of any dangers and risks inherent in such activities, I do hereby waive, release, forever discharge and hold harmless Centenary University, its officers, trustees, representatives, agents, students and employees (collectively the "University") from and against any and all claims, demands, losses, liabilities, or action for costs, expenses or damages to personal property or personal injury or death which may result from my participation in these activities whether on or off Centenary University property and regardless of the animal's owner.

Under New Jersey law, a participant and spectator are deemed to assume the inherent risks of equine animal activities created by equine animals, weather conditions, conditions of trails, riding rings, training tracks, equestrians, and all other inherent conditions. Each participant is assumed to know the range of his or her ability and it shall be the duty of each participant to conduct himself or herself within the limits of such ability to maintain control of the equine animal and to refrain from acting in a manner which may cause or contribute to the injury of the participant or others, loss or damage to person or property, or death which results from the participation in an equine animal activity. **WARNING: UNDER NEW JERSEY LAW, AN EQUESTRIAN AREA OPERATOR IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ANIMAL ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ANIMAL ACTIVITIES, PURSUANT TO P.L. 1997, c.287 (C:5:15-1 et seq.)**

I understand and admit that my participation in these activities is voluntary. I assume full responsibility for any injuries or damages resulting from my participation including responsibility for using reasonable judgment in all phases of participation of the activities and travel to and from locations. I recognize and understand that the activities may be hazardous, that my participation is solely at my own risk, and that I assume full responsibility for any resulting injuries and damages.

I affirm that I am capable of participating in such activities. In the event that I need medical treatment, I hereby consent and authorize such treatment and agree to be responsible for the cost of any medical services. I acknowledge that it is the recommendation of the University that I obtain general medical/health insurance if I am not already covered.

I understand that this Waiver of Liability, Assumption of Risk and Release binds my heirs, executors, administrators, and assigns as well as myself. This Waiver of Liability and Release shall be governed by the laws of the State of New Jersey. I acknowledge that I have read and understand this entire Waiver of Liability and Release, sign it voluntarily and I agree to be legally bound by it.

If I am under the age of eighteen (18), my parent or guardian also signs below to give permission for me to participate in shadowing activities and also agrees to be legally bound by the terms of this entire Waiver of Liability, Assumption of Risk and Release.

Please see attached summary of the New Jersey equine activity liability statute.

\_\_\_\_\_  
Participant's Printed Name

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness' Name and Witness' Signature

*Parent or Guardian Required if Participant Engaging in Shadowing Activities is under age 18:*

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

Note: Shadowing involves accompanying and observing, especially in a professional setting.

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## Authorization for Emergency Medical Treatment Form

Participant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Current medications: \_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ 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 TRAC and/or Centenary University to: (1) Secure and retain medical treatment and transportation if needed, and (2) Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/ Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Dear Health Care Provider,**

One of your patients is interested in participating in supervised equine activities. In order to safely provide this service, we request that you complete the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine-assisted activities and therapies. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

**Precautions and/or Contraindications for Therapeutic Riding Activities:**

**Orthopedic**

Atlantoaxial Instability – include neurologic symptoms  
Coxa Arthrosis  
Cranial Deficits  
Heterotopic Ossification/Myositis Ossificans  
Joint subluxation/dislocation  
Osteoporosis  
Pathologic Fractures  
Spinal Joint Fusion/Fixation  
Spinal Joint Instability/Abnormalities

**Neurologic**

Hydrocephalus/Shunt  
Seizure  
Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromelia

**Other**

Age – under 4 years  
Indwelling Catheters/Medical Equipment  
Medications – i.e. photosensitivity  
Poor endurance  
Skin Breakdown

**Medical**

Allergies  
Blood Pressure Control  
Cardiac Condition  
Exacerbations of medical conditions (i.e. RA, MS)  
Hemophilia  
Medical Instability  
Migraines  
PVD  
Respiratory Compromise  
Recent Surgeries  
Weight Control Disorders

**Psychological**

Animal Abuse  
Physical/Sexual/Emotional Abuse  
Dangerous to self or others  
Fire Settings  
Substance Abuse  
Thought Control Disorders

Thank you for your assistance! If you have questions about Equine Assisted Activities and Therapies or the services provided at Therapeutic Riding At Centenary (TRAC), please contact Karen Brittle, Director of TRAC, at [karen.brittle@centenaryuniversity.edu](mailto:karen.brittle@centenaryuniversity.edu) or (908)852-1400, ext. 2174.





## Participant's Medical History & Physician's Statement

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Past/Prospective Surgeries: \_\_\_\_\_

Medications: \_\_\_\_\_

Purpose of 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 N Wheelchair Y N

Braces/Assistive Devices: \_\_\_\_\_

**For those with Down Syndrome** - Result of neurologic exam to check for symptoms of Atlantoaxial Instability: \_\_\_\_\_

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

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that the PATH Intl center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl center for ongoing evaluation to determine eligibility for participation.

Name/Title: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_

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

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_