Sofia's Hope, Inc.
Participant Equine Activity Release

This Participant Equine Activity Liability Release, Waiver of Right to Sue and Assumption of All Risks Agreement ("the Agreement") is hereby given by _____ on his/her own behalf as a participant, AND/OR as the parent or guardian of the above named minor _____ who is a participant in or to any program, activity or event taking place under the sponsorship of Sofia's Hope, Inc. For the purposes of this RELEASE, the term Participant shall include the Participant, his or her heirs, assigns, executors, trustees, personal representatives and administrators.

Equine Activity Sponsor: SOFIA'S HOPE, INC., a Florida not-for-profit corporation (referred to herein as "Sponsor ") located at 10106 SW 126 Street, Miami, Florida. For the purposes of this RELEASE, the term Sponsor shall include the Sponsor, its directors, officers, shareholders, employees, independent contractors, volunteers, agents and Sponsor's subsidiaries and parent entities.

In consideration of the rights, privileges and benefits to me derived from participating in Sponsor's equine activities, which Participant believes outweigh the potential assumed risks, Participant agrees as follows: Participant hereby waives, releases and indemnifies (including all attorneys fees and costs) Sponsor forever from any and all claims of liability that may in the future arise from participating in Sponsor's equine activities, including but not limited to riding, grooming, handling or otherwise interacting with horses, whether on or off Sponsor's premises. The Sponsor shall not be liable for any injuries to, or the death of Participant resulting from the inherent risks of equine activities, and except as provided in Florida Statutes Section 773.03, Participant shall not have any claim against or recover from Sponsor for injury, loss, damage, or death of Participant resulting from any of the inherent risks of equine activities.

WARNING

UNDER FLORIDA 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 FROM THE INHERENT RISKS OF EQUINE ACTIVITIES. [FLORIDA STATUTE SECTION 773.04 (2)].

Participants understands that "inherent risks" of equine activities means those dangers which are an integral part of equine activities, including but not limited to: (a) the propensity of equines to behave in ways that may result in injury, harm or death to persons on or around them; (b) the unpredictability of an equine's reaction to such things, sounds, sudden movement, and unfamiliar objects, persons on or around them; (c) certain hazards such as

surface and subsurface conditions; (d) collisions with other equines or objects; (e) the potential of the Participant or other participants to act in a negligent manner that may contribute to injury to the Participant or others, such as failing to maintain control over the animal or not acting within his or her ability.

Participant represents that Participant has the sufficient skills and ability to safely manage the particular equine activities, in which Participant has now, or may in the future voluntarily, chose to participate. This RELEASE shall cover all incidents arising at anytime throughout the duration of the equine activities, and shall remain in full force and effect from the date of this RELEASE forever.

Dated this _____ day of _____, 20___

_____
Participant

I acknowledge that I am of legal age and capacity to enter into this RELEASE.

_____
Signature of Parent/Legal Guardian

PHOTO RELEASE

Further, Participant consents to and authorizes the reproduction and use by Sponsor of any and all photographs and any other audio-visual materials taken of Participants for promotional materials, new publications, educational activities, exhibitions or for any other use for the benefit of the program. I have read and understand this RELEASE and voluntarily agree to be legally bound to its terms and conditions.

_____ _____
Participant Signature of Parent/Legal Guardian

I acknowledge that I am of legal age and capacity to enter into this RELEASE.

_____ _____
Signature of Sponsor Date

Participant Authorization for Emergency Medical Treatment Form

Name: _____ DOB: _____ Phone #: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current Medications: _____

In the event of an emergency, contact:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ 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 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: _____
Rider, Parent, or Legal Guardian

Non-Consent Plan

I do not give 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.

☐Parent of legal guardian will remain on site at all times during equine assisted activities

☐In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

Date: _____ Consent Signature: _____
Client, Parent, or Legal Guardian

Winding Paths EQUESTRIAN

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Physician's Statement

Dear Health Care Provider:
Your patient _____ is interested in participating in supervised equine activities.
Participant's Name

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present and to what degree. Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please free to contact us at the address/phone below.

Orthopedic	**Medical/Psychological**	**Neurologic**
Atlantoaxial Instability -	Allergies	Hydrocephalus/shunt
Include neurological symptoms	Animal abuse	Seizure
Coxa Arthosis	Cardia condition	Spina Bifida/Chiari II malforma-
Cranial Deficits	Fire settings	tion/Tethered Cord/
Heterotopic Ossification	Blood pressure control	Hydromyelia
Joint subluxation/dislocation	Dangerous to self or others	Traumatic brain injury
Osteoporosis	Exacerbations of medical	
Pathological fractures	condition (ie. RA, MS)	
Spinal joint fusion/fixation	Hemophilia	**Other**
Spinal joint instability	Medical instability	Age - under 3 years
Abnormalities	Migraines	Indewelling catheters
Amputee	PVD	Medical equipment
	Respiratory compromise	Medications - i.e.
	Recent surgeries	photosensitivity
	Substance abuse	Poor endurance
	Thought control disorders	Skin breakdown
	Physical/sexual/emotional abuse	Post traumatic stress disorder

Past/ Prospective surgeries: _____

Medications: _____

Seizure type: _____ Controlled: Y N Date of last seizure: _____

Shunt present: Y N Date of last revision: _____

Independent amubulation: Y N Assisted ambulation: Y N Wheelchair: Y N

Braces/Assistive devices: _____

Winding Paths EQUESTRIAN

PATH INTERNATIONAL

Physician's Statement

For those with Down Syndrome: AtlantoDens Interval x-rays date: _____ Result: + -

Neurologic symptoms of Atlatnoaxial instability: _____

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

	Y	N	Degree of Impairment/Comments
Auditory			
Visual			
Tactile sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurolic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning disability			
Cognitive			
Emotional/psychological			
Pain			
Other			

Physician's Notes/Comments:

_____

_____

Physician's Signature: _____ Date: _____

Name/Title: _____ MD DO NP PA Other _____

Address: _____

Phone: _____ License/UPIN Number: _____

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PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

RIDER FORM
Sofia's Hope, Inc.

Rider Information

Rider: _____ DOB: _____ Age: _____

( ) Male ( ) Female Disability(s): _____

School/Institution attending: _____

Height: _____ Weight: _____

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

Email: _____ Phone: _____

Physician Name: _____ Phone: _____ Fax: _____

Allergies: _____

Precautions: _____

Emergency contact information:

Name: _____ Relationship: _____

Phone: _____ Cell #: _____ Work #: _____

Parent/Guardian Information

Name: _____

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

Email: _____ Phone: _____

Cell #: _____ Work# : _____

Winding Paths EQUESTRIAN

PATH INTERNATIONAL
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RIDER RULES/REGULATION FORM

1. All participants in equine assisted activities must arrive at least ten minutes prior to their session, so the staff members can fit their helmet and get them prepared for the appointment.

2. Parents and siblings are not permitted within the stable without the presence of a staff member.

3. Regardless of inclement weather, do not assume the session is cancelled. As you know, it may be raining at your house, whereas it is sunny and beautiful at the barn. We will personally call you if we are cancelling a session.

4. All parents and siblings must be quiet during therapeutic riding sessions. Horses can become spooked with sudden movements and sounds, so for safety reasons everyone involved must follow this rule. This means no running around, playing in the barn, talking or standing close to the ring. You are more than welcome to watch the class from a distance (i.e., standing away from the grass ring.

5. We understand that riders may have to cancel sessions due to illness, etc. but when possible please call twenty-four hours in advance to cancel. Please call Jennifer Allen at (305) 926-8239 to cancel and re-schedule your child's session.

Name of participant: _____

Printed Name of guardian: _____

Signature of guardian: _____

Date: _____