**PARTICIPANT WAIVER FORM**

Participating at CLT Farms Equestrian Healing Center LLC LLC (CLTFEHC) is a rewarding job but it is not without risks. While we strive to make CLTFEHC a safe environment for all of our guests, we ask that you observe our rules of safety at all times. By signing, you agree that you are participating on your own behalf and release CLTFEHC, its director, officers, board members and staff from all claims, injuries, or actions (including those of active or passive negligence) arising from any activities in which you participate at CLTFEHC. By signing, you understand the risks and hazards inherent upon entering the facility during a health crisis and assume all risks of loss, contraction of illness, damage, or injury, including death, that may be sustained while at CLTFEHC or while performing activities for CLTFEHC at one of its events or functions. By signing, you represent that you are 18 years of age and of sound mind. If you are under 18, a parent or guardian must sign this form as well.
Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:Click or tap to enter a date.
Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLT Farms Equestrian Healing Center LLC **PARTICIPANT’S HEALTH HISTORY**
Participant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: Click or tap to enter a date.Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Onset:Click or tap to enter a date.
Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Equipment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Adaptive Equipment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate current or past special needs in the following areas; Vision Y[ ]  N[ ]  Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
[ ] Hearing Sensation [ ] Communication [ ] Heart [ ] Breathing [ ] Digestion [ ] Elimination [ ] Circulation [ ] Emotional/Mental Health [ ] Behavioral [ ] Pain [ ] Bone/Joint [ ] Muscular [ ] Allergies **PARTICIPANT’S HEALTH HISTORY continued:** Describe abilities/difficulties in the following areas (include assistance required) PHYSICAL FUNCTION: i.e., Mobility skills such as transfers, walking, wheelchair use, driving, etc.) PSYCHO/SOCIAL FUNCTION ( i.e., Work/school, leisure interests, relationships, family structure, support systems, companion animals, fears/concerns, etc.) GOALS: (i.e. What do you hope to gain from participation? What would you like to accomplish?) OTHER INFORMATION WE MIGHT FIND HELPFUL?
This form was completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: Click or tap to enter a date.Relationship to participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Please write on back if more space is needed)