6657 Kimesville Road
Liberty, NC 27298
336-565-9723/ fax 336-565-0644
www.KopperTop.org

PARTICIPANT REGISTRATION FORMS

Participant's Name_____Date of Birth_____

Address_____ Gender: M F (circle one)

City/State_____ Zip Code _____

Phone: (H)_____(W)_____ Email:_____

FAMILY INFORMATION

Mother/Guardian:_____Home phone:_____

Employer:_____Work phone:_____

Address:_____City/State:_____

Father/Guardian:_____ Home hone:_____

Employer:_____Work phone:_____

Address:_____City/State:_____

Emergency Contacts: 1._____Phone:_____

2._____ Phone:_____

Physician:_____Phone:_____

Dentist:_____Phone:_____

Preferred Medical Center:_____City:_____

Insurance Carrier:_____Policy#:_____

Allergies:_____Medication/s:_____

Information about my daughter/son/ward that may assist staff in any way (medical assistance, characteristics, behaviors):_____

_____

_____

_____

_____

PERMISSION/LIABILITY RELEASE

Yes, I would like_____(participant's name) to participate in the Kopper Top Life Learning Center, Inc. therapy program—Healing HOOVES, and all therapy programs offered by the center that I choose to participate in. I understand **that NO LIABILITY** can be accepted or assigned by any organization or individual concerned with this care, including Kopper Top Life Learning Center, Inc. and the Healing HOOVEs and included therapy programs in the event of any accident, which may occur. I acknowledge the risks and potential for risks. I hereby, intending to be legally bound, for myself, my heirs and assign, executors or administrators, waive and release forever all claims for damages against Kopper Top Life Learning Center, Inc., its Board of Directors, instructors, volunteers and/or staff for any and all injuries and/or losses I/ my son/ my daughter/ my ward may sustain while participating in the Kopper Top Life Learning Center, Inc, Healing HOOVES and other therapy programs.

I do do not ***(circle one)*** give the staff/volunteers of Kopper Top Life Learning Center, Inc. permission to transport my participant via staff vehicle or Emergency Medical Services to Medical Center stated above, if I am unable to be reached in case of emergency.

Warning:
"Under North Carolina law, an equine activity sponsor or equine professional is not liable for an injury to or death of a participant in equine activities resulting exclusively from inherent risk of equine activities. Chapter 99 E of the North Carolina General Statute."

"Under North Carolina law, there is no liability for an injury to or death of a participant in an agritourism activity conducted at this agritourism location if such injury or death results from inherent risks of the agritourism activity. Inherent risks of agritourism include, among others, risks of injury inherent to land, equipment, and animals, as well as the potential for you to act in a negligent manner that may contribute to your injury or death. You are assuming the risk of participating in this agritourism activity."

Signature of Parent(s)/Legal Guardian

_____ _____
Signature Date

PHOTO RELEASE

I do do not ***(circle one)*** consent to and authorize the use and reproduction by Kopper Top Life Learning Center, Inc. and it's partner program, Elon University and students, of any and all photographs and any other audio/visual materials taken of me/my participant, for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

_____ _____
Signature Date

AUTHORIZATION for EMERGENCY MEDICAL TREATMENT FORM

Participant

Name:_____DOB:_____Phone:_____

Address:_____City/State/Zip:_____

Physician's Name:_____Preferred Medical Facility:_____

Health Insurance Company:_____ Policy #:_____

Allergies to Medication:_____

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 on the property of the agency, I authorize Kopper Top Life Learning Center 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-rays, 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:_____ Signature:_____

Participant, Parent or Legal Guardian

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in 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:_____ Signature:_____

Participant, Parent or Legal Guardian

Signed in the presence of center staff

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM.

Participant's Medical History & Physician's Statement

Participant:_____DOB:_____Height_____Weight_____

Address:_____

Diagnosis:_____Date of Onset:_____

Past/Prospective Surgeries:_____

Medications:_____

Seizure Type:_____

Medications:_____

SeizureType:_____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: AtlantoDens Interval X-rays, date:_____Result: + -

Neurologic Symptoms of AtlantoAxial Instability: _____

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

Special Need	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the NARHA 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
(eg. PT, OT, SLP, Psychologist, etc.) in the implementation or an effective equine activity program.

Name/Title:_____MD DO NP PA Other _____
Signature_____Date_____
Address:_____
Phone:( )_____License/UPIN Number_____