Manna's HANA Riding Center
Address: 1285 Brotherton Drive
Cookeville, TN 38506
Office: 931-349-8106 Fax: 931-754-1132
Email: mannahana@gmail.com

Lambs "2" Lions Application

Name: _____

DOB: ____/____/_____ Age: _____ Height: _____ Weight: _____ Gender: __M __F

Address:_____

Email address: _____

Referral Source: _____ Phone: _____

How did you hear about the program? _____

This program is a hands-on learning experience working with the horse. Horses give an instant feedback to responses from the youth. At this point in the program, there is no riding the horses.

We offer youth a unique opportunity designed to promote emotional growth such as building positive relationships, increasing self-confidence, understanding nonverbal communication, improving emotional regulation, and demonstrating responsibility and empathy for others in order to increase independence in their role as a student and as a growing individual. They will be given an opportunity for positive engagement through the utilization of a variety of equine experiential activities.

Students will meet Wednesdays from 3:30pm till 5:00pm.

While at Manna's Hana Riding Center, they will be given a snack & drink, work with the horses, help feed the horses and muck (help clean the stalls and paddock area).

Lambs "2" Lions Program is free for your youth through grants and generous donors in our community contributing to this program.

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RELEASE AND INDEMNITY AGREEMENT FOR PARTICIPANTS

In recognition of the fact that I will be acting as a participant at Manna's Hana Riding Center, Inc. property located at 1285 Brotherton Drive, Cookeville, Tennessee and recognizing that interacting with and around horses is an inherently risky behavior, I hereby intending to be legally bound, for myself, my heirs and assigns, executors or administrators, do hereby release, absolve, indemnify and hold harmless Manna's Hana Riding Center, Inc., its representatives, supervisors, directors, officers, employees, suppliers, corporate sponsors or any volunteers from any damages, injuries, claims, suits or costs arising in any way out of the conduct of the activities of the Manna's Hana Riding Center, Inc. program, including any injury which may occur at the Manna's Hana Riding Center, Inc. facilities or in transit to or from Manna's Hana Riding Center, Inc. facilities or related events, except such liability or claim of liability as may result from gross negligence on the part of Manna's Hana Riding Center, Inc. I am executing this release with a full understanding that I will be interacting closely with horses during my visit.

WARNING

Under Tennessee law, an equine professional is not liable for an injury or death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to Tennessee Code Annotated, Title 44, Chapter 20, Section1.

Dated this _____ / _____,/_____
Month Day Year

Participant's Name: _____

Participant's Signature: _____

Parent/Guardian's Signature: _____

Phone: _____

Complete Address: _____

PHOTO RELEASE

☐ **I Do** ☐ **I DO NOT**

consent to and authorize the use and reproduction by Manna's Hana 'Lambs 2 Lions of any and all photographs and any other audio/visual materials taken of me for promotional material, education activities, exhibitions or for any other use for the benefit of the program.

Dated this _____ **/** _____**,/**_____ **Consent Signature:** _____
Month **Day** **Year** **Parent/Guardian**

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FOR DOCTOR!!! **Attach with next page for physical signatures**

Date: _____

Dear Health Care Provider:

Your patient: _____
(Participant's name)

Is interested in supervised equine activities in our Lambs 2 Lions Program. We are offering equine assisted activities.

In order to safely provide this service, our center request that you complete/update the attached Medical History and Physician's Statement Form. Please note 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.

Orthopedic	**Medical/Psychological**
Atlantoaxial Instability	Allergies
Coxa Atthrosis	Animal Abuse
Cranial Deficits	Cardiac Condition
Heterotopic Ossification/Myositis Ossificans	Physical/ Sexual/Emotional Abuse
Joint subluxation/dislocation	Blood Pressure Control
Osteoporosis	Dangerous to self or others
Pathologic Fractures	Exacerbations of medical conditions (i.e. RA, MS)
Spinal Joint Fusion/Fixation	Fire Settings
Spinal Joint Instability/Abnormalities	Hemophilia
	Medical Instability
Neurologic	Migraines
Hydrocephalus/Shunt	PVD
Seizure	Respiratory Compromise
Spina Bifida/Char II malformation/tethered Cord Hydromyelia	Recent Surgeries
	Substance Abuse
Other	Thought Control Disorder
Age – under 4 years	Weight Control Disorder
Indwelling Catheters/Medical Equipment	
Medications – i.e. photosensitivity	
Poor Endurance	
Skin Breakdown	

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the phone number listed above.

Sincerely,
Bobbie Abell, Executive Director

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Participant's Medical History & Physician's Statement (for Doctor)

Participant: _____DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of onset: _____

Past/Prospective Surgeries: _____

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

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

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

Physician's Statement:

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

Name/Title: _____ MD *DO NP Other*: _____

Signature: _____ Date: _____ Phone: _____

Address: _____ **License/UPIN Number:** _____