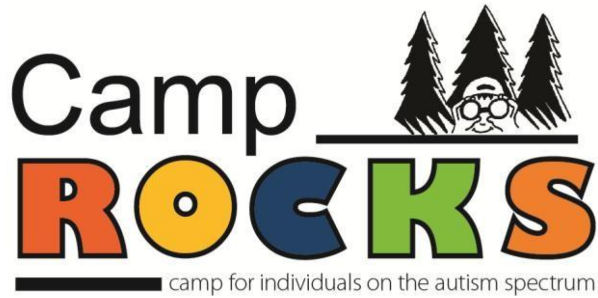

CAMPER APPLICATION 2018

Please return completed form to:

Mail
Bonnie Fisher
Easterseals Crossroads
4740 Kingsway Drive
Indianapolis, IN 46205

Email
bfisher@eastersealscrossroads.org

Fax
Bonnie Fisher
317.466.2000

APPLICATION INSTRUCTIONS

- All **application materials** in this packet are due by **APRIL 30, 2018.**

- The **physician release and Agape Registration** (separate documents) are due **by April 30, 2018.**
    - We encourage you to schedule your child(s) appointment for his/her camp physical with your physician now to assure that these forms are completed by the deadline. **Not having these forms could result in your child being put on standby and accepted only if space is available.**

- Agape Therapeutic Riding is a separate organization that is housed at Bradford Woods and runs our therapeutic riding program in the summer. We apologize that these forms may seem to be duplications, but they need their own forms as they are a separate entity.

- At this point, we are collecting applications only – additional forms and payment information will follow when your camper is accepted and assigned to a camp session.

- If you have any questions or require additional information, please do not hesitate to call us at **317.466.1000 x2488.**

Camper Name: ___________________________________

ALL FORMS MUST BE COMPLETELY FILLED OUT. ***PLEASE PRINT CLEARLY.***

CAMPER INFORMATION

First Name: ___________________________ Last Name: _______________________________ Goes By: _____________________________
Birth date_____ /_____ /_____ Age _____ Sex ________________ Weight ______ Height ______

Primary Diagnosis:____

Date of Onset: _________________________________Degree: ☐ Slight ☐ Moderate ☐ Severe

Secondary Diagnosis:____

Date of Onset:________________________________ Degree: ☐ Slight ☐ Moderate ☐ Severe

Your camper's T-shirt size: **ADULT -** ☐ SMALL ☐ MEDIUM ☐ LARGE ☐ XL ☐ XXL ☐ XXXL
YOUTH - ☐ SMALL ☐ MEDIUM ☐ LARGE

PARENT/ GUARDIAN INFORMATION

CAMPER IS HIS/HER OWN GUARDIAN: ☐ YES ☐ NO

Parent/Guardian 1:

First Name: _____________________ Last Name: ______________________________ Email: ___________________________________

Street Address ____

City _______________________________________State ______________ Zip Code ________________County______________________

Main Phone Number (_________) ________________________________ Type: ☐ Mobile ☐ Home ☐ Work

Other Phone Number (_________) ________________________________Type: ☐ Mobile ☐ Home ☐ Work

When is the best time to reach you? ☐ Morning ☐ Afternoon ☐ Evening ☐ Other _______________________

Relationship to camper: ____

Marital Status: ________________________________

Parent/Guardian 2:

First Name: _____________________ Last Name: ______________________________ Email: ___________________________________

Street Address ____

City _______________________________________State ______________ Zip Code ________________County______________________

Main Phone Number (_________) ________________________________ Type: ☐ Mobile ☐ Home ☐ Work

Other Phone Number (_________) ________________________________Type: ☐ Mobile ☐ Home ☐ Work

When is the best time to reach you? ☐ Morning ☐ Afternoon ☐ Evening ☐ Other _______________________

Relationship to camper: ____

Marital Status: ________________________________

In case of an emergency, if the parent/guardian cannot be reached, please contact:

Name: ____ Phone: ___________________ Relationship to Camper: _________________

Name: ____ Phone: ___________________ Relationship to Camper: _________________

Camper Name: ____

CAMPER MEDICAL HISTORY

To be completed by camper's parent/guardian. ***PLEASE PRINT CLEARLY!***

Diet: ☐ Normal ☐ Blended/Pureed ☐ Gluten Free ☐ Vegetarian ☐ Diabetes
☐ Other ____
____
____

Mobility: ☐ Walks ☐Uses Walker ☐Uses Wheelchair; can operate/drive self? ☐ Yes ☐ No
☐ Orthotic Braces/Ankle-Foot orthosis (AFO) ☐ Cane

Seizures: ☐YES ☐NO Type: ___________________ Frequency: _________________________
Describe any warning signs before seizures: ____
____
What steps are taken at home once your camper has a seizure? ____
____
Is your camper medicated for seizures? ☐ YES ☐ NO Date of last seizure: _______________________

Allergies: (Check all that apply)
☐ None ☐ Pollen ☐ Poison Ivy ☐ Latex ☐ Animals ☐ Bee/Insects ☐Food
☐ Medications ☐ Peanuts ☐ Other ____________________
If allergic to medications or food, please list:
____
Describe any allergic reactions: ____
____

Respiratory: (Check all that apply)
☐ Tracheotomy ☐ CPAP ☐ BiPAP ☐ Nebulizer ☐ Other ____________________________________
If so, describe: ____
Bowel:
How frequent are your camper's bowel movements? ☐ Daily ☐ Every Other Day ☐ Once a Week
☐ Twice per Week ☐ Three Times per Week ☐ Other ____
Do your camper's "bathroom habits" change in different environments? ☐YES ☐NO
Explain: ____
Does your camper wear diapers/ briefs/depends? ☐YES ☐NO
Explain: ____

Feminine Needs:
Does your camper menstruate? ☐YES ☐NO
Do you have any special treatment for cramps? ____
List feminine products used and if assistance is needed: ____
____

Camper Name: __________________________________

Camp Activities:
Are there any activities your camper should **not** participate in? ☐ YES ☐ NO
If yes, list: ____

Swimming:
Can Camper Swim independently? ☐ YES ☐ NO
If NO, please explain assistance needed (water wings, personal flotation device, counselor assistance)
____
Does you camper experience a pain crisis after swimming? ☐ YES ☐ NO

Special Equipment: (check all that apply)
☐ Orthopedic Devices ☐ Glasses ☐ Contacts ☐ Dentures ☐ Earplugs ☐ Helmet ☐ Catheter
☐ Ostomy ☐ Feeding Tube ☐ Hearing Aid ☐ Orthodontic Braces ☐ Dental Appliances
☐ Other: _________________________
If yes, what type of assistance is needed? Any special instructions ______________________________________
____
____

Sleeping Behavior:
☐ Typical sleeping habits ☐ Has trouble going to sleep ☐ Has nightmares ☐ Wets bed
☐ Sleep walks ☐ Runs Away
☐ Special routine ____
____
Usual bedtime __________________________Usual wake up time ______________________________

Hospitalizations:
Please list recent surgeries *(within the last 12 months)*: ____
____
Please list recent hospitalizations *(within the last 12 months)*: ____
____

Physical Health History:

Conditions	**YES**	**NO**	**If yes, please explain**
Back Problems			
Clotting			
Dizziness/Passing Out			
Heart Murmur			
HIV			
Joint Problems			
Mono *(within in last 12 months)*			
Skin Problems *(itching, rash, etc.)*			
Bleeding			
Chest Pain			

Camper Name: ________________________________

Head Injury			
High Blood Pressure			
Immunodeficiency			
Lice			
Shunt *(indicate side)*			
Diabetes			
Asthma			
Visual Impairment			

Medications:
Please indicate the total number of medications your camper is taking, including prescription, over-the-counter medications, supplements, vitamins, etc.: ___________________________

Dates of Immunizations:
Measles, Mumps, Rubella: ____________ Tetanus-diphtheria Toxoid: ___________ H. Influenza: ___________
Pneumonia: ___________ Last TB Skin Test: ___________ Results: ______________________
DPT Series: 1) ___________ 2) ___________ 3) ___________ 4) ___________ 5) ___________
Polio Series: 1) ___________ 2) ___________ 3) ___________ Chicken Pox: 1) ___________
Hepatitis B: 1) ___________ 2) ___________ 3) ___________

CAMPER MENTAL, SOCIAL, AND EMOTIONAL HEALTH

Family Changes and Homesickness	**Yes**	**No**
Has the applicant gone through any significant family changes? (death, divorce, adoption, abuse, etc.)	☐	☐

If yes, please describe.

Are you concerned about the applicant's ability to cope with homesickness? If yes, please explain why. ☐ ☐

Camper Name: ___________________________________

Mental, Emotional, and Social Health History

- ☐ Attention Deficit Disorder (ADD or AD/HD)
- ☐ Obsessive-Compulsive Disorder
- ☐ Disordered Eating
- ☐ Learning or Processing Challenge
- ☐ Suspended or Expelled from School
- ☐ Other Mental, Emotional, or Social Health Issue
- ☐ Depression
- ☐ Panic, Anxiety Disorder
- ☐ Substance Abuse
- ☐ Self-harming or Suicidal Ideation
- ☐ Personality Disorder

**** Please note that indicating these does not necessarily preclude your camper from attending camp. ****

For each mental, emotional, or social health concern indicated on the previous page, please provide details on the treatment of the condition and the effect (if any) it will have on their experience at camp by using the questionnaire on the next page. If no indication is made, please write DOES NOT APPLY in the boxes below.

Concerns	Yes	No
Has the applicant received professional treatment for this issue?	☐	☐
Is the applicant currently taking prescription medication for this issue?	☐	☐
Has the applicant gone through any significant family changes? (death, divorce, adoption, abuse, etc.)	☐	☐

Management Regimen
What are some management techniques that are used to manage this issue?

Indication of Change in Mental Health Status
List behaviors that would indicate your child's emotional state is fluctuating (i.e. your child is becoming irritated, depressed, overwhelmed, etc.)

Camper Name: ______________________________

Does your camper have emotional outbursts? ☐ YES ☐ NO
What seems to trigger the outburst? ____
During an outburst, what is normally done at home to calm him/her down?
____
____
____

GENERAL INFORMATION

Cabin Option: Is your camper interested in staying in a gender-inclusive cabin during the camp session, either for personal reasons or to support other campers? ☐ YES ☐ NO

Behavior Modification/Management: Are there any specific behaviors or skills you have been working on, or would recommend working on as a proposed behavior modification/management goal (i.e. independent washing of hands, use of silverware, appropriate eye contact, decrease inappropriate behaviors, etc.)?
____
____
____
____

Communication: ☐ No serious difficulties expressing thoughts or wants ☐ Has difficulty
☐ Uses Sign Language ☐Uses a communication device ☐PEC Board ☐ Non-verbal
☐ Hearing impaired; partial or total: _______________
Describe: ____
____

Education: ☐ Reading skills: To what degree? ____
☐ Writing skills: To what degree? ____
☐ Math skills: To what degree? ____
Does your camper attend school: ☐ YES ☐ NO ☐ GRADUATED Grade Enrolled *(if applicable)* _____________
What age level does your camper function within a social context? (Indicate months/years with age) ________
Is your camper in a special education class? Yes ___ No ___ Other ________________________

Camper Likes: Please list any activities, foods, noises/music, etc. that your camper likes, or that help your camper to relax
____
____
____

Camper Dislikes: Please list any activities, foods, noises/music, etc. that tend to agitate or upset your camper
____
____
____

Camper Name: ___________________________________

Travel: Please list any alternate family or friends that have permission to pick up your camper up from camp. Individuals not listed will NOT be allowed to pick up your camper.

First Name *Last Name* *Relation to camper* *Cell phone number*

____

____

____

PERSONAL CARE & SKILLS

Indicate if your camper can perform the requested skill **independently** and/or explain any assistance needed. **PLEASE PRINT**. Check yes or no. Place a line (-) through the sections if not applicable.

PERSONAL CARE	YES	NO	EXPLANATION OF ASSISTANCE NEEDED
Uses the toilet			
Washes hands and face			
Brushes teeth			
Takes shower			
Combs/ brushes hair			
Dresses self: Underwear/brief			
T-shirt/jacket			
Pants/shorts			
Shoes & socks			
Other			

MOBILITY/FINE & GROSS MOTOR SKILLS	YES	NO	EXPLANATION OF ASSISTANCE NEEDED
Can support self while sitting			
Operate own wheelchair *(if applicable)*			
Transfers from seat to chair/from bed to chair			
Uses crutches/walker			
Can roll over in bed			
Grasps and releases objects			
Other			

MEALTIME NEEDS	YES	NO	EXPLANATION OF ASSISTANCE NEEDED
Can feed self with fork/spoon independently			
Can feed self with finger food			
Can swallow whole foods			
Can hold cup or glass independently			
Uses adaptive utensils			
Knows when he/she is full			
Drinks through a straw			
Other feeding instructions			

Camper Name: ______________________________

BEHAVIORS:	Has your camper ever displayed the following? Please check for each			**Explanation**
Hitting	☐ Current	☐ Past	☐ Never	
Pinching	☐ Current	☐ Past	☐ Never	
Hair Pulling	☐ Current	☐ Past	☐ Never	
Biting	☐ Current	☐ Past	☐ Never	
Kicking	☐ Current	☐ Past	☐ Never	
Spitting	☐ Current	☐ Past	☐ Never	
Scratching	☐ Current	☐ Past	☐ Never	
Bullying	☐ Current	☐ Past	☐ Never	
Stealing	☐ Current	☐ Past	☐ Never	
Lying	☐ Current	☐ Past	☐ Never	
Swearing	☐ Current	☐ Past	☐ Never	
Wandering	☐ Current	☐ Past	☐ Never	
Withdrawal	☐ Current	☐ Past	☐ Never	
Impulsivity	☐ Current	☐ Past	☐ Never	
Non-compliance	☐ Current	☐ Past	☐ Never	
Mood swings	☐ Current	☐ Past	☐ Never	
Verbal Threats	☐ Current	☐ Past	☐ Never	
Throwing Objects	☐ Current	☐ Past	☐ Never	
Hand Flapping	☐ Current	☐ Past	☐ Never	
Head Banging	☐ Current	☐ Past	☐ Never	
Rocking	☐ Current	☐ Past	☐ Never	
Inflicts self-injury	☐ Current	☐ Past	☐ Never	
Disrobing	☐ Current	☐ Past	☐ Never	
Anxiety/depression	☐ Current	☐ Past	☐ Never	
Sexual acting out	☐ Current	☐ Past	☐ Never	
Genital stimulation	☐ Current	☐ Past	☐ Never	
Suicidal ideation	☐ Current	☐ Past	☐ Never	

If there any additional comments, concerns, medical or behavioral information <u>we need to know about</u>, please list here: ____

____

____

____

____

____

____

Camper Name: ___________________________________

RECREATION THERAPY CAMPER ASSESSMENT

Camper: ________________________________ **Camp Name:** ________________________________

Camp Goal: (Identify one goal the camper would like to accomplish at camp)

Please *circle* the description that best represents the camper and write in additional comments

Does your camper have sensory stimulation needs? Yes No

Low Sensory Need		Moderate Sensory Need		High Sensory Need
1	2	3	4	5

Areas for improvement: ____

Healthy Leisure Lifestyle (how active is the camper in recreation activities and hobbies)

Low Participation		Moderate Participation		High Participation
1	2	3	4	5

Areas for improvement: ____

Independence (in home setting)

Displays Low Independence		Displays Moderate Independence		Displays High Independence
1	2	3	4	5

Areas for improvement: ____

Social Skills (outside of camp)

Avoids Social Interactions		Tolerates Social Settings		Actively Engages in Social Interactions
1	2	3	4	5

Areas for improvement: ____

Friendships (outside of camp)

Has few or no friendships		Has some friendships		Has many friendships
1	2	3	4	5

Areas for improvement: ____

Social Acceptance (outside of camp)

Doesn't feel accepted by peers		Feels somewhat accepted by peers		Feels accepted by peers
1	2	3	4	5

Areas for improvement: ____

Physical Activity Level (outside of camp)

Low Participation		Moderate Participation		High Participation
1	2	3	4	5

Areas for improvement: ____

Opportunity to be with other youth that have the same diagnosis (outside of camp)

Never		Sometimes		Often
1	2	3	4	5

Areas for improvement: ____

Frustration Tolerance

Low Frustration Tolerance		Moderate Frustration Tolerance		High Frustration Tolerance
1	2	3	4	5

Areas for improvement: ____

Camper Name: ________________________________

INSURANCE

Is your camper covered by hospitalization insurance? ☐YES ☐NO

Carrier: ______________________________ Policy/Group#: _________________________________

Medicare #: ______________________ Medicaid #: _____________________________________

A copy of your camper's insurance, Medicaid or Medicare card is required. Please supply a copy of BOTH the FRONT and BACK of the card. Please provide a current picture of your camper that mainly shows his/her face.

COPY of Front of Insurance Card

COPY of Back of Insurance Card

Recent Photograph of Your Camper

Camper Name: _________________________________

TEACHER CONSENT

Note to Teacher: The following information is extremely important to help Bradford Woods staff and camp medical team determine the best cabin placement for the child. Please be specific so we can provide the best camping experience possible for your student.

Camper's Name: ________________________________

Camper's School: ________________________________

School Address: ________________________________

____

____

Teacher(s) Name: ________________________________

Phone: ____

E-mail: ____

At what age level is the child functioning?
(Indicate months/years with age) __________

At what age level is the child functioning within a social context? (Indicate months/years with age) __________

Is the child in a special education class? Yes ___ No ___
If so, what type? ________________________________

Please describe child's receptive communication ability.

____

____

____

____

____

Please describe child's expressive communication ability.

____

____

____

____

____

Please explain specific behavioral difficulties and successful management techniques, if any.

____

____

____

____

____

What level of personal care does child receive at school (mobility, feeding, toileting, number of people required to assist, etc.)?

____

____

____

____

Does this child have a 1:1 aide in the classroom?
Yes ___No ___

If yes, what is the aide's focus (e.g. academic support, physical assistance, behavioral support)?

____

____

____

____

To best support the camper in an accessible outdoor environment, what staff-to-child ratio would you suggest?
1:1 _____ 1:2 _____ 1:3 _____ 1:4 _____ 1:5 _____
Please briefly explain:

____

____

____

Teacher's Signature ______________________________

Date ____

Camper Name: ________________________________

Authorization to use Likeness/Information/Photo Release

Consumer Name ____

Date of Birth ____

I, or my legal representative, understand and agree that any narratives, depictions, pictures, film, photographs, audio-visual or sound recordings or testimonials of me made by Easterseals Crossroads or its respective employees and agents may be used by Easterseals Crossroads and those acting with its permission for the purpose of illustration, broadcast, or testimonial in connection with the work of Easterseals Crossroads and that these materials may be released to the general public. I assign to Easterseals Crossroads all of my rights to these materials.

I understand that these materials made by Easterseals Crossroads, its employees and agents are owned by Easterseals Crossroads and that they may copyright them. I further consent to allow Easterseals Crossroads, their respective employees and agents, and those acting with Easterseals Crossroads' permission to use my protected health information, as defined under 45 C.F.R. 164.501, for the purpose of illustration, broadcast, or testimonial in connection with any work of Easterseals Crossroads and to release this information to the general public.

I understand that these materials may be published by Easterseals Crossroads on the Internet. This may disclose my image, name and diagnosis, which is considered personal and protected health information. Easterseals Crossroads does not need to submit these materials to me for further approval and I further understand that Easterseals Crossroads may decide not to use these materials.

I acknowledge that the rights described above are granted to Easterseals Crossroads on an unlimited basis without any compensation or payment being made for any current or future use. I understand that this authorization is voluntary and that Easterseals Crossroads will not condition any treatment or funding to me on the completion of this authorization. I also understand that I may revoke my consent to allow Easterseals Crossroads to release my protected health information, including image, name and diagnosis if the information has not already been disclosed. To revoke my consent, I must notify Easterseals Crossroads in writing by sending my revocation to Easterseals Crossroads, Marketing Department, 4740 Kingsway Drive, Indianapolis, IN 46205.

I understand and agree that once Easterseals Crossroads, its respective employees and agents, and those acting with its permission disclose my protected health information, including image, name and diagnosis, as contemplated by this release, this information is subject to re-disclosure and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. This release and authorization expires five years from the date of my signature below. I have read this release and authorization before signing below, and I fully understand its contents.

____ ______________________

Signature of Consumer or Legal Representative *Date*

____ ______________________

Printed Name of Consumer or Legal Representative *Relationship to Consumer*

____ ______________________

Witness *Date*

Camper Name: ______________________________

Physician Release for Bradford Woods 2018

*****This form must be filled out and signed by a *PHYSICIAN******

Your camper will not be officially accepted into camp until Bradford Woods has received this form.
This form is due NO LATER than May 15

To my knowledge, there is no reason why this person cannot participate in horseback riding, recreational activities, waterfront activities (swimming/canoeing/water skiing/fishing/boat rides), music therapy, arts and crafts, archery, and high ropes initiatives (rock wall/zip line). However, I understand the Bradford Woods will evaluate the medical information that has been provided in relation to the existing Bradford Woods's precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc), in the implementation of an effective equine activity program.

Camper may participate in all camp activities excluding:

____
____
____

Jarring Toleration:
☐ YES ☐ NO For activities at the horse barn such as horseback riding, can the camper tolerate jarring?
If no, please explain: ____
____

Name/Title (please print) ________________________________ MD DO NP PA Other: ____________________

Signature: ____

Address: ____

Phone (_________) ______________________________________ Date _____________________

******FOR PERSON WITH DOWN SYNDROME******

Full Flexion and Extension X-rays for Atlantoaxial Instability (AAI) *is required* prior to entering Agape Therapeutic Riding Center at Bradford Woods. ***This neurological exam must be completed within one calendar year of Camp.*** Annual physical examination should reveal no symptoms of AAI. Follow-up X-rays should be every 10 years after.

*****NO INDIVIDUAL MAY RIDE WITH POSITIVE SYMPTOMS OF AAI*****

Neurologic exam reveals symptoms consistent with atlantoaxial instability? Yes _____ No _____

Date of Exam: _______________ Physician's initials: __________

Camper Name: ____________________________________

Agape Therapeutic Horseback Riding

Camper Name: ____

Camp Session: ____

Photo and Media Consent

Agape Therapeutic Riding Resources, Inc. requests that the above-listed Agape Equine Participant consent to and authorize the use and reproduction by Agape Therapeutic Riding Resources, Inc. of any and all photographs and any other audio-visual materials taken of the above-listed Agape Equine Participant for publication in promotion material, educational activities, exhibitions, publications, broadcasts, website and any other use which promotes Agape Therapeutic Riding Resources, Inc. and its programs.

Please check *only* one: ____ I do consent. ____ I do **not** consent.

Health History Signature

I hereby affirm that, to the best of my knowledge, the health history information provided within this application is complete and correct.

Name of person completing this form: ____

Relationship to Participant: _____________________

Signature: ____ Date: ________________

EQUINE ACTIVITY RELEASE, ASSUMPTION OF RISK AND AGREEMENT TO INDEMNIFY

This *Equine Activity Release, Assumption of Risk and Agreement to Indemnify* (the "Agreement") is hereby entered by on the dates indicated below.

A. Scope of Services Provided. Agape Therapeutic Riding Resources, Inc. ("Agape") is a not-for-profit organization that sponsors, organizes and/or provides facilities for activities involving equines including, but not limited to, therapeutic riding and equine-facilitated learning programs with such activities taking place both on the premises owned by Agape ("Premises") and at other locations within the State of Indiana ("Locations") (collectively "Agape Equine Activities").

B. Inherent Risks of Equine Activities. The undersigned expressly understands that certain dangers or conditions are an integral part of such Agape Equine Activities including but not limited to: i) The propensity of an equine to behave in ways that may result in injury, harm, or death to persons on or around the equine, ii) The unpredictability of an equine's reaction to such things as sound, sudden movement, unfamiliar objects, people, or other animals, iii) Hazards such as surface and subsurface conditions, iv) Collisions with other equines or objects and v) The potential of a person involved in Agape Equine Activities to act in a negligent manner that may contribute to injury to that person and/or other persons, such as by failing to maintain control over an equine. **The undersigned expressly understands and agrees that such dangers or conditions exist whether a person is: i) personally engaging in Agape Equine Activities, ii) a spectator of Agape Equine Activities or iii) entering, departing or being on the Premises or Locations where Agape Equine Activities are taking place and that by doing any of these actions, such a person is a "Participant."**

C. Assumption of Risk, Release and Waiver of Liability and Indemnity Agreement. In consideration of Agape allowing the undersigned, as well as those persons for whom the undersigned has listed herein, to be a Participant and with an understanding of the Inherent Risks of Equine Activities as set forth in Paragraph B above, the undersigned, individually and on behalf of each persons listed herein by the undersigned, hereby assumes all such risks and forever releases, waives, discharges and covenants not to sue Agape Therapeutic Riding Resources, Inc. (including its directors, officers, shareholders, employees, agents, representatives, volunteers, insurers, affiliates, successors, assigns and others acting on Agape Therapeutic Riding Resources, Inc.'s behalf including, without limitation, independent contractors such as trainers, instructors, veterinary personnel, farriers, equine care providers and maintenance personnel) (collectively the "Released Parties") from all liability, loss, claims, demands, possible causes of action, court costs, attorneys' fees and other expenses, known or unknown, anticipated or unanticipated, that may result from any loss, damage or injury (including death) to the person or property of i) the undersigned and ii) each person listed herein by the undersigned which, in any way, results from, or arises in connection with, or relates to, any Agape Equine Activity whether caused by the negligence of the Released Parties or others. The undersigned further hereby agree to indemnify and hold harmless the Released Parties and each of them from any and all loss, liability, damage or cost they may incur due to the undersigned and each person listed herein by the undersigned being a Participant whether caused by the negligence of the Released Parties or otherwise.

The undersigned agrees that the Indemnification Agreement shall also apply as to any loss, liability; damage or cost incurred by persons and their property who have not executed an *Equine Activity Release, Assumption of All Risk and Agreement to Indemnify* but who the undersigned invited or otherwise encouraged to be a Participant.

D. Binding Effect. This Agreement shall be binding upon the heirs, executors, administrators, agents, insurers and assigns of the undersigned and shall inure to the benefit of and may be enforced by the Released Parties. **If this Agreement is executed for and on behalf of a Participant who is under the age of eighteen (18) or under some other legal disability, the undersigned hereby represents and warrants that he or she is in fact the legal parent or guardian of said Participant**

Camper Name: ___________________________________

with full rights of custody and control and that this Agreement and all terms contained herein is given on behalf of and is intended to be binding upon said Participant, his/her heirs, executors, administrators, agents, insurers and assigns.
E. Complete Agreement, Choice of Law, Venue and Attorneys Fees. The terms of this Agreement contain the entire agreement of the parties as to the subject matter set forth herein and shall be governed by the laws of the State of Indiana. In the event any provision of this Agreement is deemed to be invalid or unenforceable by any court or administrative agency of competent jurisdiction, then the Agreement shall be deemed to be restricted in scope or otherwise modified to the extent necessary to render its provisions valid and enforceable. The parties agree that Hamilton County, Indiana is the exclusive venue for any legal proceedings arising from or related to this Agreement and the Released Parties shall be entitled to recover the costs incurred (including reasonable attorney's fees) from the undersigned in the event that any legal action (regardless of whether a lawsuit is filed) is required to enforce this Agreement.

I HAVE FULLY READ AND FULLY UNDERSTAND THIS EQUINE ACTIVITY RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF ALL RISK AND AGREEMENT TO INDEMNIFY. I UNDERSTAND THAT, BY SIGNING THIS DOCUMENT, I MAY BE WAIVING AND RELEASING CERTAIN IMPORTANT RIGHTS WHICH I MIGHT HAVE IF I DID NOT SIGN THIS AGREEMENT. I AM SIGNING THIS DOCUMENT VOLUNTARILY AND WITHOUT ANY COERCION.

ADULT/GUARDIAN(S) FULL NAME

____
Signature and Date

____
Name

EACH PARTICIPANT UNDER THE AGE OF 18 OR OTHERWISE UNDER A LEGAL DISABILITY FOR WHOM EACH ADULT PARTICIPANT IS SIGNING (Please Print):

____
Signature and Date

____
Name

WARNING
Under Indiana law, an 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.

Camper Name: ___________________________________