



Participant Registration Packet & Release Forms

Participant's Last Name: _____ First Name: _____ Date of Birth: _____

Street Address: _____ City: _____ Zip: _____

County: _____ Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____ Email Address: _____

Participant's Ethnicity: _____ Gender: _____ Weight: _____ Height: _____

Primary Disability: _____ Other Disabilities: _____

Adaptations: _____

Is the Participant a U.S. Military Veteran? ____ Yes OR ____ No

If you answered Yes to the question above, which branch did you serve? _____

What are your dates of service? _____

Name of Parent/Guardian (if Participant is under 18 years old): _____

Parent/Guardian's Cell Phone: (____) _____ Parent/Guardian's Work Phone: (____) _____

Parent/Guardian's Place of Employment: _____ City: _____

Does the Participant qualify for Medicaid funding or long term support? ____ Yes OR ____ No

If you answered Yes to the question above, check which program applies to the participant, and write the name of his/or county and case manager:

☐ Children's Long Term Support Waiver (CLTS) County: _____ Case Manager: _____

☐ Community Care Options Program (CCOP) County: _____ Case Manager: _____

☐ Comprehensive Community Services (CCS) County: _____ Service Facilitator: _____

☐ Other: _____ County: _____ Case Manager: _____

Leave this Box Blank. (For HGR Staff Use Only During Participant's Intake Assessment)

Based on all information provided, the Participant will be enrolled in the following program at HGR:

☐ Equine Services for Heroes

☐ Equine-Assisted Learning

☐ Therapeutic Riding



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Has the participant ever ridden a horse? Circle: YES or NO

List of activities, sports, games, and/or reinforcements that the participant enjoys:

List of activities, sports, games, objects etc. that the participant dislikes/fears:

Physical Abilities (Mobility, transfer skills, walking): _____

Psycho/Social Abilities: _____

What benefits would you like to obtain through HGR's programs & services? List goals here:

Photo Release

(Please check one):

I do _____ / I do NOT _____ consent to and authorize the use and reproduction by Heaven's Gait Ranch of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions, or for any other use for the benefit of the organization.

Signature _____ Date: _____

(Participant, Parent or Guardian if under 18)

Liability Release

_____(Participant's Name) would like to participate in equine assisted services at Heaven's Gait Ranch. I acknowledge the risks and potential for risks of horseback riding and other equine assisted services. However, I feel the possible benefits of myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Heaven's Gait Ranch, Inc., its Board of Directors, Instructors, Trainers, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in programs at Heaven's Gait Ranch.

Signature: _____ Date: _____

(Participant, Parent or Guardian of under 18)



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Rider's Authorization/Emergency Medical Treatment

In the event of an emergency that 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 Heaven's Gait Ranch to do the following: secure and retain medical treatment and transportation if needed and release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Emergency Contact Numbers

Primary Contact in case of emergency: _____ Phone: _____
Secondary Contact in case of emergency: _____ Phone: _____
Physician's Name: _____ Phone: _____
Preferred Medical Facility: _____ City: _____
Health Insurance Co: _____ Policy #: _____

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 emergency contacts are unable to be reached.

Date: _____ Print Name: _____ Phone: _____

Consent Signature: _____
(Participant, Parent or Guardian if Participant is under 18 years old)



Dear Health Care Provider:

Your patient _____

(Participant's Name)

is interested in participating in programs and/or services at Heaven's Gait Ranch, Inc. In order to safely provide our services under the Professional Association of Therapeutic Horsemanship (PATH Intl.), our center requests that you complete the attached Medical History and Physician's Statement Forms. Please note that the following conditions may suggest precautions and contraindications to mounted activities and/or therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic	Medical/Psychological
Atlantoaxial Instability (include neurologic symptoms)	Allergies
Coxarthrosis	Animal Abuse
Cranial Defects	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 (e.g., RA, MS)
Spinal Joint Fusion/Fixation	Fire Setting
Spinal Joint Instability/Abnormalities	Hemophilia
Neurologic:	Medical Instability
Hydrocephalus/Shunt	Migraines
Seizure	PVD
Sensory Deficit	Respiratory Compromise
Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia	Recent Surgeries
Other:	Substance Abuse
Age (under 4 years)	Thought Control Disorders
Indwelling Catheters/Medical Equipment	Weight Control Disorder
Medications (e.g., photosensitivity)	
Poor Endurance	
Skin Breakdown	



Participant's Medical History

***Note: The participant's physician must complete this form. Parent/Guardian signature is also required.**

Participant's Name: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Primary Diagnosis: _____ Date of Onset: _____

Current Status: _____

Secondary Diagnosis: _____ Date of Onset: _____

Current Status: _____

Past Surgeries: _____ Date: _____

Prospective Surgeries: _____ Date: _____

Medications (include prescription and over-the-counter, name, dose, and frequency):

Side Effects: _____

Does this participant have a history of seizures? Yes: _____ No: _____

If yes, please provide the following information.

Triggers: _____ Type of Seizure: _____

Controlled: Yes: _____ No: _____ Date of Last Seizure: _____

Shunt Present: Yes: _____ No: _____ Date of last revision: _____

Special Precautions/Needs: _____

Mobility Assessment:

Independent Ambulation: Yes: _____ No: _____

Assisted Ambulation: Yes: _____ No: _____

Wheelchair: Yes: _____ No: _____

Braces/Assistive Devices: _____

Date of last Atlantoaxial Instability neurologic exam: _____

(Required if participant has Down Syndrome)

Physician Signature _____ Date: _____

Date: _____

Signature of Participant / Parent or Guardian (if participant is under 18 years old)



Participant's Physician's Statement

***Note: The participant's physician must complete this form.**

Please complete the following chart based on your knowledge of this participant.

Does the participant have a history of concerns in the following areas? Indicate yes or no. Add comments to explain.

Category	Yes	No	Comments	Category	Yes	No	Comments
Auditory				Muscular			
Visual				Balance			
Tactile Sensation				Orthopedic			
Speech				Allergies			
Cardiac				Learning Disability			
Circulatory				Cognitive			
Integumentary/Skin				Emotional			
Immunity				Psychological			
Pulmonary				Pain			
Neurologic				Other			

Additional Comments:

Physician's Statement

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

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

Signature: _____ Date: _____

Address: _____

Phone: (____) _____ EXT _____ License/UPIN Number: _____



Participant Safety Policies & Agreement

To ensure the quality and safety of our therapeutic riding lessons for our riders, volunteers, and horses, we have established the following policies at Heaven's Gait Ranch. Please read and sign the agreement below.

Riders

- Any rider 150 pounds or more must be able to independently remain centered and balanced on his or her horse so that side walkers are not required for primary physical assistance.
- Heaven's Gait Ranch reserves the right to determine whether mounted or unmounted equine activities are safe and appropriate for both horse and rider. This may vary from week to week.
- If a person is not eligible for therapeutic horseback riding, Heaven's Gait Ranch offers alternative equine-assisted activities that do not require mounting. Participants may still build relationships with our horses by grooming, feeding, bathing, and caring for them in a safe environment.
- All participants must wear an approved riding helmet (ASTM-SEI Certified) during equine activities, both mounted and/or ground. Helmets are provided by Heaven's Gait Ranch for participant use. Staff assist with proper fit and adjustments prior to the start of each lesson.
- Because safety and consistency come first at HGR, riders may be dismissed from our program for the following reasons. This determination will be made by Instructors and the Program Coordinator. If a rider is dismissed from HGR's program, a prorated refund will be issued.
 - A rider, his or her guardian, or visitor engages in unsafe, combative, or disruptive behavior toward staff, volunteers, or horses.
 - A rider, his or her guardian, or visitor does not follow HGR's policies & procedures on site.
 - A rider's deteriorating health begins to contraindicate horseback riding.
 - A rider misses three consecutive, unexcused absences (unless for medical reasons)
 - A rider, his or her guardian, or visitor is destructive to property at Heaven's Gait Ranch.
 - A rider, his or her guardian, or visitor attends their scheduled lesson time under the influence of illicit drugs or alcohol

Horses

- As our horses age, we must be conscious and considerate of their needs, just as we would for our riders. For most of our horses, therapeutic riding has become their second, third, or even fourth career; therefore, some require weight limits for health reasons. The staff and volunteers at HGR strive to keep all of our horses healthy, safe, and sound; however, there may be times when the horses available may not be suitable for certain riders. This determination will be made on an ongoing basis, and HGR will adjust teams accordingly.
- If a horse's health no longer permits him to safely perform mounted activities, staff, volunteers, and participants at Heaven's Gait Ranch will care for him through nurturing and meaningful groundwork as he enjoys retirement.

The staff, volunteers, and horses at Heaven's Gait Ranch thanks you in advance for adhering to these safety standards!

Participant Safety Agreement

I have read the rider safety policies at Heaven's Gait Ranch. I understand the expectations for participants, riders, their parents or guardians, and visitors at this PATH International Member Center.

Participant /Parent/Guardian's Signature (if participant is under 18 years old)

Date: _____



HGR's Program Fees & Cancellation Policy Agreement

In 2026, our operating budget was approved by Sheboygan County Health and Human Services, valuing our service rate for specialized recreation and/or counseling and therapeutic services at \$299.57 per lesson. Due to rising costs, our 2027 budget, including rider fees, has not yet been finalized.

Veterans: For over ten years, HGR has relied heavily on the generosity of its donors to provide equine services to veterans at no charge. We remain committed to sponsoring veteran lessons 100% through the ongoing gratitude and generosity of our donors.

Private Pay: We also fundraise to provide heavily subsidized scholarships for families seeking services who privately pay and qualify for financial assistance. Families with questions on how to apply should inquire with our Program Coordinator about the Andy Mueller Memorial Scholarship. Available scholarship funds vary from season to season.

CLTS and CCS: From 2018-2026, HGR has been an approved provider for various counties under the Children's Long Term Support Waiver (CLTS). CLTS currently pays up to a cap rate of \$178.50 per lesson through 2026, while donations to HGR offset the true cost. As of 10/14/2026, however, the Children's Long Term Support Waiver has not yet relayed its terms and rates for providers over the next five years. HGR will know more about approved or denied authorizations as well as service rates as we approach the end of 2026. Participants enrolled in Sheboygan or Ozaukee County Comprehensive Community Services (CCS) currently qualify for funding through the Department of Health and Human Services.

HGR's Cancellation Policy

Occasionally HGR will cancel lessons due to extreme weather or on site working conditions; participants will not be charged whenever HGR initiates a cancellation. When it's raining/snowing, alternative activities are safely planned for the day in the barn, which may include unmounted activities or telehealth, remote services. All staff come to work because they're expecting their participants to show. The lesson fee is the same whether the participant engages in mounted or unmounted activities.

If a participant cancels within 24 hours of their scheduled lesson time, then the participant is personally charged \$50.00/lesson. This includes families who pay out of pocket, participants on scholarship, and participants funded by county agencies. We understand that health emergencies arise; however, if a participant misses three consecutive lessons, then they will lose their allotted day and time for the remainder of the session. Participants may not begin a new session with an outstanding balance from previous lessons provided or last minute cancellations initiated by the participant/family.

Participant Cancellation Policy Agreement

I read and acknowledge the information written above, including HGR's Program Fees & Cancellation Policy. I understand HGR's policy, and I agree to privately pay for the full cost of my lesson if/when I cancel within 24 hours of my scheduled lesson time.

Participant/Parent/Guardian's Signature (if participant is under 18 years old)

Date:_____