Youth Registration & Release
Please Circle: *Participant / Volunteer*

Name:	Pronouns:
Date of Birth:	Age:
If Riding - Horse riding information: Weight:	Height: Horse Experience:
Name of Parent/Guardian:	
Relationship to participant:	
Street Address:	City:
State: Zip:	Cell #: Home #:
Email Address:	
Do you wish to receive email newsletters from Unbridled Spirit? ▁ Yes ▁ No	
Alternate Household *(if applicable):* Name	
Address:	Phone:
Email Address:	
How did you hear about Unbridled Spirit?	

Liability Release:

_____(Participant's name) would like to participate in Unbridled Spirit programming. I acknowledge the potential risks of horse and farm activities. However, I feel that the possible benefits to myself/ my son/ daughter/ 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 Windy Acres and Unbridled Spirit, Facilitators, Therapists, and Volunteers for any and all injuries and/or losses I/ my son/ my daughter/ my ward may sustain while participating in Unbridled Spirit programming. I understand that these programs may include therapeutic energy clearing.

Date: _____ Signature:_____

Participant (if over 18) or Parent or Guardian

Photo Release (OPTIONAL):

I hereby consent to and authorize the use and reproduction by Unbridled Spirit and their contracted services/funders of any and all photographs and any other audiovisual materials taken of me/ my son/ my daughter/ my ward for promotional printed materials, educational activities or for any other use for the benefit of the program.

Date: _____ Signature:_____

Participant,(if over 18) Parent or Guardian

Participant / Volunteer Emergency Authorization

In the event emergency 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 Unbridled Spirit to secure and retain medical treatment and transportation if needed.

Emergency Contact:	Phone:
Relationship to participant:	
Emergency Contact:	Phone:
Relationship to participant:	
Name of physician:	Phone:
Health Insurance Co:	Policy #:
Preferred Medical Facility:	

Consent Plan

I give consent for emergency medical treatment. This authorization includes x-ray, surgery, hospitalization, and medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Print Name:	Relationship to participant:
Signature:	Date:

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. **In the event of emergency treatment/aid is required, I wish the following procedures to take place:**

Print Name:	Relationship to participant:
Signature:	Date:

Participant / Volunteer Emergency Authorization Medical & Social History

Full Name:		
Form completed by:		Relationship:
Any allergies?	Date of last tetanus	Any reaction to bee stings?
Any medications the participant will be taking during programs?		
Any health reasons to limit your/ your youth's activities at farm? Any dietary restrictions?		

General Health Questions: Complete information is needed to insure facilitators' awareness and sensitivity to the participant's behavior and needs, and will not be used to screen out participants. Please mark yes or no for each question.

	Yes	***No***
1. Any recent injury, illness, or infectious disease?	☐	☐
2. Chronic recurring illness/condition?	☐	☐
3. Frequent headaches?	☐	☐
4. Ever had a head injury?	☐	☐
5. Wear glasses, contacts, or protective eyewear?	☐	☐
6. Use mobility device(s) or hearing aids?	☐	☐
7. Ever passed out during or after exercise?	☐	☐
8. Ever had seizures?	☐	☐
9. Chest pain during or after exercise?	☐	☐
10. High blood pressure?	☐	☐
11. Back problems?	☐	☐
12. Joint problems (e.g. knees, ankles)?	☐	☐
13. Orthodontic appliance or headgear being used?	☐	☐
14. Any skin problems (e.g., allergies, rash, hives)?	☐	☐
15. Diabetic?	☐	☐
16. Asthmatic?	☐	☐
17. ADD/ADHD diagnosed?	☐	☐
18. Short or long-term memory impairment?	☐	☐
19. Tendencies toward emotional/violent outburst or inflicting harm to self, others or animals?	☐	☐
20. Tendencies toward emotional/physical isolation?	☐	☐

Please explain any "yes" answers, noting the number of the question.

Participant / Volunteer Demographics

We appreciate you taking time to include your demographic data as it helps us greatly in seeking funding for our youth and families. It **helps provide donors a basis for understanding our community needs.** It can be a powerful tool for tracking community change over time and for uncovering the needs or strengths of a community to guide planning, policy development or decision making.

Participant Resides in:

- ☐ Town or Rural Non-farm (pop. 10,000 or less)
- ☐ Town or City (pop. 10,000-50,000)
- ☐ Suburb (pop. 50,000 or more)
- ☐ City (pop. 50,000 or more)
- ☐ Reservation
- ☐ Farm
- ☐ Other

Participant lives with:

- ☐ 1 Biological Parent
- ☐ Both Biological Parents
- ☐ Blended Family
- ☐ Alternates between 2 parents' homes
- ☐ Other Relative
- ☐ Foster Family
- ☐ Adoptive Family
- ☐ Other: _____

Racial/Ethnic Group

- ☐ Caucasian
- ☐ African American
- ☐ Native American
- ☐ Hispanic/Latino
- ☐ Asian/Pacific Islander

Other: _____

Please mark which grade the participant is attending:

- ☐ 1st
- ☐ 2nd
- ☐ 3rd
- ☐ 4th
- ☐ 5th
- ☐ 6th
- ☐ 7th
- ☐ 8th
- ☐ 9th
- ☐ 10th
- ☐ 11th
- ☐ 12th
- ☐ Not attending

Check if 'Yes' for Participants only *(Volunteers do not need to complete this section)*

- ☐ Has the participant ever resided with anyone other than his/her birth family?
- ☐ Is the participant struggling academically?
- ☐ Is the participant struggling behaviorally or emotionally in school?
- ☐ Is the participant struggling behaviorally or emotionally in social situations?
- ☐ Is the participant struggling behaviorally or emotionally at home?
- ☐ Has the participant or a close family member ever been incarcerated?
- ☐ Has the participant witnessed or experienced domestic violence?
- ☐ Has the participant or a close family member abused/had any problems with alcohol or drugs?
- ☐ Is a close family member active in the military or a veteran?
- ☐ Does the participant identify as LGBTQ?

Participant Only: Please state Goals for the Participant:

Areas of growth needed:

- Clear Communication
- Connection with others
- Speaking up for oneself and/or boundaries
- Trust
- Self Confidence
- Taking responsibility
- Problem solving
- Anxiety

Other:

Participant/ Volunteer - Exceptions to Confidentiality

The privacy of your personal information is of utmost importance. Unbridled Spirit is compliant with current Federal and State of Washington laws. Federal and State laws limit confidentiality. ANT may use or disclose your personal health information when I am required or permitted to do so by law, or in the following situations:

a) Duty to warn: Participant's personal health information may be disclosed if we determine a need to alert an intended victim of a serious threat to their health or safety. For example, this may occur if participants reveal intentions to kill or harm another person. Staff of Unbridled Spirit are obligated to take necessary action to avert a serious threat to the health and safety of others.

b) Danger to participant: Participant's personal health information may be disclosed if staff of Unbridled Spirit determine that participants may kill or seriously harm themselves. For example, this may occur if participants reveal that they are planning to commit suicide. Staff are obligated to take necessary action to avert a serious threat to the health or safety of participants.

c) Child or elder abuse or neglect: Participant's personal health information may be disclosed if they report or Unbridled Spirit staff reasonably suspects any child or elder abuse or neglect. For example, if participants reveal that they have physically harmed a child then we will need to notify Child Protective Services (CPS).

d) Court order: Participant's personal health information may be disclosed if Unbridled Spirit is presented with a court order to do so. For example, this may occur if participants have legal involvement and a judge or law enforcement agency has called Unbridled Spirit staff to testify or release records.

e) Crime against Unbridled Spirit premises: participant's personal health information may be disclosed if they commit or threaten to commit a crime against Unbridled Spirit staff or facility. This includes damage to property.

f) Other disclosures: participant's personal health information may be disclosed for research when approved by an institutional review board, to military or national security agencies, coroner, medical examiners, and correctional institutions or otherwise as authorized by law. Participant's personal health information may be disclosed to necessary parties involved if you file a legal or administrative claim against Unbridled Spirit or staff. Your identifying information may be disclosed to debt collection agency personnel if you fail to pay for professional services by our agreed upon time period.

Date: _____ Signature:_____

Participant if over 18 years old , Parent or Guardian