



Freedom Farm
 11500 Ferman Avenue SW
 Waverly, MN 55390
 952-955-2505
 info@freedomfarmmn.org www.freedomfarmMN.org

2017 Freedom Farm 'Hope with Horses' Student Participant Release and Agreement (Pg 1 of 3)

Name: _____ DOB: _____
 Mailing Address: _____ City _____, **MN** ZIP _____
 E-mail _____ (please add info@freedomfarmmn.org to your safe list)
 Phone: (Home) _____ (Parent Cell) _____
 Work Phone _____ (Student Cell) _____

Health History

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Include fitness, cardiac, respiratory, bone or joint function, recent hospitalizations, surgeries, or lifestyle changes.

Recent medical tests: _____ Last Tetanus Shot: _____ (not required)
 Physician's Name: _____ Preferred Medical Facility: _____
 Health Insurance Company: _____ Policy # _____
 Current medications: _____

Allergies (include medications): _____

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 Freedom Farm 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.

**** PLEASE CHOOSE ONE ****

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person(s) below is unable to be reached.

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 emergency treatment/aid is required, **I wish the following procedures to take place:** _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____
 Name: _____ Relation: _____ Phone: _____

The information provided above is accurate to the best of my knowledge.
 I know of no reason why this student should not participate in this center's program.

Parent/Guardian Signature: _____ **Date:** _____



Freedom Farm
 11500 Ferman Avenue SW
 Waverly, MN 55390
 952-955-2505
 info@freedomfarmmn.org www.freedomfarmMN.org

2017 Freedom Farm 'Hope with Horses' Student Participant Release and Agreement (Pg 2 of 3)

Name _____

1. Photo Release

I ___ DO ___ DO NOT consent to and authorize the use and reproduction by Freedom Farm 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 center. This may include Freedom Farm Facebook page, website and newspapers.

Parent/Guardian Signature: _____ **Date:** _____

Student Signature: _____ **Date:** _____

2. Confidentiality Agreement

I understand that all information (written and verbal) about participants at this PATH center is confidential and will not be shared with anyone without the expressed written consent of the participant and their parent/ guardian in the case of a minor. ****Do not take pictures of participants with cell phones while at Freedom Farm nor post anything regarding participants on Facebook or other social media.****

Parent/Guardian Signature: _____ **Date:** _____

Student Signature: _____ **Date:** _____

3. Student Agreements

A) Student understands that **SMOKING IS PROHIBITED** on the grounds of **FREEDOM FARM**. All tobacco products, lighters, matches, etc. prohibited.

Parent/Guardian Initials: _____ **Students Initials:** _____

B) Student understands that this program has 2 phases.

PHASE 1: Training to develop skills that will allow the student to participate in PHASE 2.

PHASE 2: Includes working with Watertown/Mayer Special Education Students to assist them during their therapeutic riding lessons.

Parent/Guardian Initials: _____ **Students Initials:** _____

C) Student understands that **CELL PHONES** will be placed in a safe, secure designated area upon arrival to Freedom Farm. Cell Phones will not be used during Hope with Horses and Cell Phones will be returned at the end of the session.

Parent/Guardian Initials: _____ **Students Initials:** _____

D) Student understands that **I-Pads** will be placed in a safe, secure designated area upon arrival to Freedom Farm. I-Pads will not be used during 'Hope with Horses' and I-Pads will be returned at the end of the session.

Parent/Guardian Initials: _____ **Students Initials:** _____

E) Student understands that if a problem occurs that raises concern for safety of students (self or others), participants, equine or staff, case worker or police will be notified immediately.

Parent/Guardian Initials: _____ **Students Initials:** _____

We have read and understand the policies and expectations of Freedom Farm and the 'Hope with Horses' Program.

Parent/Guardian Signature: _____ **Date:** _____

Student Signature: _____ **Date:** _____



Freedom Farm
11500 Ferman Avenue SW
Waverly, MN 55390
952-955-2505
info@freedomfarmmn.org www.freedomfarmMN.org

2017 Freedom Farm 'Hope with Horses' Student Participant Release and Agreement (Pg 3 of 3)

1. I, _____, (herein called Releasor), in consideration of being permitted to use the facilities and services of Bjorklund Training Stable /Freedom Farm for himself/herself, spouse, my minor child, legal representatives, heirs and assigns, HEREBY RELEASES, WAIVES AND DISCHARGES BJORKLUND TRAINING STABLE/FREEDOM FARM, (HEREIN CALLED RELEASEE) THE OWNERS AND LESSEES OF BJORKLUND TRAINING STABLE/FREEDOM FARM INCLUDING TOM BJORKLUND AND SUSAN BJORKLUND THEIR AGENTS, EMPLOYEES AND VOLUNTEERS, FROM ALL LIABILITY TO THE RELEASOR, THEIR SPOUSE, LEGAL REPRESENTATIVES, HEIRS AND ASSIGNS, FOR ANY AND ALL LOSS OR DAMAGE, AND ANY CLAIM OR DAMAGES RESULTING THEREFROM ON ACCOUNT OF INJURY TO RELEASOR'S PERSON, EVEN INJURY RESULTING IN DEATH OF THE RELEASOR, WHETHER CAUSED BY THE NEGLIGENCE OF RELEASOR OR OTHERWISE WHILE THE RELEASOR IS RIDING, WORKING, OR FOR ANY PURPOSE USING THE FACILITIES, EQUIPMENT OR SERVICES OF BJORKLUND TRAINING STABLE/FREEDOM FARM.

2. I agree to indemnify Bjorklund Training Stable/Freedom Farm, Tom Bjorklund, Susan Bjorklund and each of them from any loss, damage or cost they may incur due to the participation or use of the facilities, equipment and services of Releasee due to the presence of myself or my minor child in or upon the property owned, located at or controlled by Bjorklund Training Stable/Freedom Farm whether caused by the negligence of the Releasees or otherwise.

3. I fully understand any involvement with horses involves some risk of harm or injury to myself, my minor child, my horses or my other property and that risk of damage or injury is a normal incident of involvement with horse-related activities and I hereby agree that risk is borne by me and/or my minor child and not by Bjorklund Training Stables/Freedom Farm, Tom Bjorklund or Susan Bjorklund, or their officers, members, agents, employees or volunteers.

THIS RELEASE CONTAINS THE ENTIRE AGREEMENT BETWEEN THE PARTIES HERETO AND THE TERMS OF THIS RELEASE ARE CONTRACTUAL AND NOT A MERE RECITAL.

I HAVE CAREFULLY READ THE FOREGOING RELEASE AND KNOW THE CONTENTS THEREOF AND SIGNED THIS RELEASE AS MY OWN FREE ACT.

Releasor _____ Date _____

Minor aged volunteer (under 18) _____

Watertown-Mayer Public Schools ~ ISD #111

Consent to Release Private Data

This form allows information about your child to be exchanged with non-school personnel.

Students Full Name

____ / ____ / ____
Date of Birth

School (Check one) PS ELEM MS HS

Grade _____

I authorize *Watertown-Mayer Public Schools, ISD #111*

____ to release information to:

____ to obtain information from:

Name Title: Susie Bjorklund

Organization: Freedom Farm

Address: 11500 Ferman Ave SW

City State ZIP: Waverly, MN 55390

The information to be released/obtained (Check all that apply):

Official School Records (name, address, birth date, sex, attendance record, grade level, grades, class rank, standardized test results)

Special Education Records Health/Medical Records & Reports Social Work Report

Teacher, Counselor, Staff Observations Psychological Report Psychiatric Report

Legal/Law Enforcement Records & Reports Other _____

chemical Abuse/Dependency Report Other _____

I understand that this authorization takes effect the day that I sign it. I also understand that I may change or cancel this authorization at any time by submitting a written request to the school district.

Parent Name

Parent Signature

____ / ____ / ____
Date

In accordance with federal and state statutes, permission of the parent of adult student is not needed when authorized school personnel request records.

Copies: Student File

Revised September 11 S-2 White