Main Stay Therapeutic Farm
6919 Keystone Road
Richmond IL 60071
815-653-9374 | info@mainstayfarm.org

2026 Client Registration and Release + Health History Form

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City State Zip/Postal

Year started riding at Main Stay:_____

For new riders, how did you hear about Main Stay:_____

Parent/Spouse/Guardian:_____

Address if different from above:_____

Contact information:

☐ *Please check if any information has changed so we can update our records*

Email:	2nd Email:
Primary Phone:	2nd Phone:

Current weight: _____ (Please be accurate as this affects our client weight limit requirements and the needs of our horses)

Rider T-Shirt Size (please circle one): Child - S M L XL | Adult - S M L XL XXL

Diagnosis (please list all relevant):_____

_____

Medications that the client is currently taking, including any over-the-counter-medications (include dosage):

_____

_____

Any hospitalizations and/or surgeries within the last year? Yes _____ No _____

If yes, please describe:_____

_____

_____

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Please indicate current or past problems in the following areas:

	Y	N	Comments
Allergies			
Behavioral			
Bone/Joint			
Breathing			
Circulation			
Communication			
Digestion Elimination			
Emotional/Psychological			
Hearing			
Heart			
Muscular			
Pain			
Sensation			
Speech			
Thinking/Cognition			
Vision			
Other			

MOBILITY: (i.e. mobility skills such as walking, wheelchair use, transfers, driving/bus riding)

_____

_____

_____

FAMILY: (please share information on any siblings or other family members important to the client)

_____

_____

_____

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SOCIAL: (i.e. work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

_____

_____

_____

OTHER: Are there any other physical, emotional or cognitive changes that have occurred in the last year? If yes, please describe. Please provide any other information that will enhance the client's lesson:

_____

_____

GOALS: (i.e. what would the client like to accomplish)

_____

_____

_____

☐ I attest that this information is accurate (to the best of my knowledge). Main Stay Therapeutic Farm reserves the right to require an annual Medical History and Physician's Statement from any client.

☐ **I have read and agree to abide by the information in the Client Handbook including the financial and weather policies.** I agree to release, indemnify and hold Main Stay (and its officers, directors and employees) harmless from any injury or loss arising out of any inaccurately reported or omitted medical information.

LIABILITY RELEASE

_____ (Rider) would like to participate in the Main Stay Therapeutic Farm, Inc. programs. I acknowledge the risks and the potential for risks of equine and animal interactions in a farm setting. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risks 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 Main Stay Therapeutic Farm, Inc., its Board of Directors, instructors, therapists, aides, volunteers and/or employees for any and all injuries and/or losses I/my son/my daughter/ may sustain while participating in a Main Stay Therapeutic Farm, Inc. program.

Under the Equine Activity Liability Act, each participant who engages in an equine or animal activity expressly assumes the risks of engaging in and legal responsibility for injury, loss, or damage to person or property resulting from the risk of equine activities. ~IL PWA-89-0111~

Date: _____ Signature: _____

***Adult** Client, Parent or Guardian*

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2026 Photo Release

Please print the names below for clients, caregivers, spouses, guardians, and minor children who may accompany the client to the farm. Circle “Do” or “Do Not” to grant consent/non-consent.

Client’s Name:_____ **DO** **or** **DO NOT**

Caregivers/Guardians/Minor children:_____ **DO** **or** **DO NOT**

_____

hereby grant irrevocable and unlimited consent to the use and reproduction by Main Stay Therapeutic Farm, Inc., PATH Intl., its assigns, licensees and legal representatives, of any and all photographs and any other audio/visual materials taken of me, my child or my ward, in all forms and media (including but not limited to printed media, digital media, web sites, video and audio productions). The materials may be reproduced in all forms including composite, altered or derivative works, for promotional material, educational activities, exhibitions or for any other lawful use for the benefit of the program.

I hereby waive the right to inspect and approve the finished version(s) including any copy that may accompany the materials. I hereby release Main Stay, PATH Intl. and its employees, volunteers, assigns, licensees and legal representatives from all claims and liability relating to said materials. I sign this release as a person with, or the parent or guardian of a person with special needs, understanding that use of these materials will make them available to the general public.

I have read and understand the above release, am over 18 and have the capacity to sign this release of my own free will.

Signature:_____ Date:_____

OR:

I am the parent/spouse/guardian of the client named above and have the legal authority to execute the above release. I approve the foregoing and waive any rights in the premises.

Signature:_____ Date:_____

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2026 CONSENT FOR RELEASE OF INFORMATION

Main Stay will not use or share your health information without your written permission unless authorized by law.

Periodically we may want to consult with other agencies/therapists with which you are working. Please provide their name(s) and address(s) below.

I hereby authorize _____
(Person(s) or facility - please list all institutions associated with the client)

_____

_____
(Complete address and phone number of person(s) and/or facility)

to release information from the records of _____

The information is to be released to Main Stay Therapeutic Farm for the purpose of developing an adaptive riding program and/or animal assisted learning program for the above named client. The information to be released is marked below.

____ Medical History
____ Physical Therapy evaluation, assessment and program plan
____ Occupational Therapy evaluation, assessment and program plan
____ Speech therapy evaluation, assessment and program plan
____ Mental Health evaluation, assessment and program plan
____ Individual Habilitation Plan (I.H.P.)
____ Classroom Individual Education Plan (I.E.P.)
____ Cognitive-Behavioral evaluation, assessment, and/or management plan
____ Other

This release is valid for one year and can be revoked in writing, at my request. Please send materials to the address listed above.

Signature(s): _____ Date:_____

Relationship to Client _____

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2026 FUNDRAISING SUPPORT

To keep our fees as low as possible, we need your help. Main Stay relies on a variety of funding sources to provide programming including:

- Grants
- Employer Matching Gifts
- In-kind donations for supplies and auction items
- Remember Main Stay in your will
- General Donations

You can assist us by sharing your employer's information if they have a matching program and/or contact details for individuals you know who might be interested in supporting our mission. Please reach out to our Executive Director, Loriann Dowell, ldowell@mainstayfarm.org, if you'd like more information about our funding opportunities.

Employer Name, address, email and phone: _____

_____

_____

Other Contacts (please list your relationship or what capacity they may be able to help):

Name, address, email and phone:_____

_____

Name, address, email and phone:_____

_____

_____

☐ **Please contact me! I'm interested in learning more about how I can help Main Stay raise vital funds.**

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2026 AUTO-PAYMENT RELEASE

Main Stay offers an optional automatic payment plan. Invoices will be sent out on the first of the month. On or around the 20th of the month, your payment can be made by using a credit card that is kept on file with us. If you wish to participate, please complete the information below. No additional charges will be paid with this card outside of the lesson fees and yearly registration fee unless you are notified.

I, _____(credit card holder) acknowledge that Main Stay Therapeutic Farm is authorized to use this card to pay monthly session/registration fees on behalf of _____. I acknowledge this agreement is good through the end of this riding season or sooner if we no longer participate in the program.

Card Holder Name:_____

Billing address of card holder: _____

_____

_____

Card # _____

Visa / Mastercard / Discover / American Express

Expiration Date: _____ CVV Code: _____

Signature of Card Holder: _____

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2026 REGISTRATION & RELEASE FORM FOR **PARENT/SPOUSE/CAREGIVER/GUARDIAN**

Name(s) of all those who may accompany rider to the farm: Date of Birth:

1.	1.
2.	2.
3.	3.

Address:		City:		State	
Cell Phone:		Email:			
Emergency Contact (name & phone):					
Medical Information in case of emergency:					

LIABILITY RELEASE

I/We would like to participate in the Main Stay Therapeutic Farm, Inc. programs. I acknowledge the risks and the potential for risks of equine and animal interactions in a farm setting. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risks 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 Main Stay Therapeutic Farm, Inc., its Board of Directors, instructors, therapists, aides, volunteers and/or employees for any and all injuries and/or losses I/my son/my daughter/ may sustain while participating in a Main Stay Therapeutic Farm, Inc. program.

Under the Equine ActivityLiability Act, each participantwhoengagesin anequine or animalactivity expressly assumes the risks of engaging in and legal responsibility for injury, loss, or damage to person or property resulting from the risk of equine activities. ~IL PWA-89-0111~

Date: _____ Signature: _____ (over 18)
Name

Date: _____ Signature: _____ (over 18)
Name