

Client's Name _____

Date _____

**RIDER REGISTRATION; RELEASE OF LIABILITY; PHOTO RELEASE;
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**
(Please complete both sides.)

RIDER REGISTRATION

Date: _____

Client's Name: _____ DOB (MM/DD/YY): _____ Age: _____

Address: _____

City, State, Zip: _____ Home Phone: _____

School or Institution presently attending: _____

Did Client attend a Pre-school (*Circle one*) Yes No

If Yes, Pre-school attended: _____

Parents' or Guardians' Full Names: _____

Parents' or Guardians' Address: _____

City, State, Zip: _____

Phone – Daytime: _____ Evening: _____ Emergency: _____

In the event I cannot be reached:

Contact: _____ Phone: _____

Contact: _____ Phone: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Co: _____ Policy #: _____

What other organizations is this Client involved in? _____

Describe in the space below any additional information that might help us to work with this client (including goals and any relevant information from the IEP). *Thank you for your time!*

RELEASE OF LIABILITY

I UNDERSTAND THAT BY SIGNING THIS DOCUMENT I AM GIVING UP LEGAL RIGHTS ON BEHALF OF MYSELF OR ON BEHALF OF A CHILD FOR WHOM I AM RESPONSIBLE. I HAVE READ THIS FORM CAREFULLY AND UNDERSTAND IT.

I, _____, wish to participate, or to have my child/ward, _____, participate in the therapeutic riding program offered by Greystone Manor Therapeutic Riding Center (Greystone Manor TRC) , or I wish to personally participate in such program as a volunteer. I am aware that horseback riding is an inherently dangerous activity. Even the most carefully trained and supervised horses are capable of inflicting serious injury. I understand that my child/ward, or I, as the case may be, cannot be allowed to participate in the program unless I release any possible liability claims against the program, and it is my desire to do so by signing this document. I hereby release Greystone Manor TRC, its employees, volunteers, officers and directors, from any liability or any injury which might be sustained by myself or by my child/ward for injuries or death sustained as a result of participation in the therapeutic riding program, even if the injuries are the result of negligence on behalf of Greystone Manor TRC, its program or its employees and volunteers. This release shall also extend to any injuries caused by the negligence of Greystone Manor TRC or its employees, or the Worship Center, for any negligence on their part as well.

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

PHOTO RELEASE (optional)

I hereby consent to and authorize the use and reproduction by Greystone Manor TRC of any and all photographs and any other audio-visual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the program.

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

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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 Greystone Manor TRC to: (1) secure and retain medical treatment and transportation if needed; and (2) release volunteer records upon request to the authorized individual or agency involved in the medical emergency treatment.

Physician's Name: _____ Phone: _____
Preferred Medical Facility: _____
Health Insurance Company: _____ Policy No.: _____

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 the person listed below is unable to be reached.

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

Printed name: _____ Phone: _____
Address: _____ City, State, Zip: _____

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 on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place: _____

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

Physician's Name: _____ Phone: _____
Preferred Medical Facility: _____
Health Insurance Company: _____ Policy No.: _____