

VOLUNTEER REGISTRATION:

Liability Release, Photo Release, Authorization for Emergency Medical Treatment

(Please complete both sides)

Name: _____ DOB (MM/DD/YY): _____ Age: _____

Parent or Guardian (if under 18) _____

Address: _____

City, State, and Zip: _____

E-mail Address: _____

Phone: Home _____ Work _____ Cell _____

Emergency Contact: _____

Relationship: _____ Home Phone: _____ Work Phone: _____

Address: _____

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, 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 Therapeutic Riding Center, 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 Therapeutic Riding Center, its program or its employees and volunteers. I agree to indemnify and hold Greystone Manor Therapeutic Riding Center harmless of and from any and all claims, actions, causes of action, and losses, including reasonable attorney fees and court costs, arising out of or in conjunction with any matter and/or endeavor undertaken by me/ my child/ ward in the course of my services to Greystone Manor Therapeutic Riding Center. This release shall also extend to any injuries caused by the negligence of Greystone Manor Therapeutic Riding Center or its employees, or The Worship Center, for any negligence on their part as well.

Date: _____

Signature of Volunteer/Parent/Guardian

LIABILITY INSURANCE COVERAGE

I understand and accept that Greystone Manor Therapeutic Riding Center does not carry liability insurance that covers injuries or general liability for volunteers. I understand that I must obtain such coverage on my own.

Date: _____

Signature of Volunteer/Parent/Guardian

PHOTO RELEASE (optional)

I hereby consent to and authorize the use and reproduction by Greystone Manor Therapeutic Riding Center of any and all photographs and any other audio-visual materials taken of me/my child/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 Therapeutic Riding Center to:

- (1) Secure and retain medical treatment and transportation if needed;
- (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, and 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.: _____

POLICY OF CONFIDENTIALITY

I understand that all information including but not limited to personal, medical, and financial documents are confidential among all participants, volunteers, and staff. Confidentiality is considered one of the most basic responsibilities for Greystone Manor Therapeutic Riding Center.

Date: _____

Signature of Volunteer/Parent/Guardian