HIDDEN ACRES THERAPEUTIC RIDING CENTER, LLC
SPECIALTY PROGRAM
LIBILITY RELEASE & AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Participant Name: _____ D.O.B. _____Age:_____
Weight: _____ Height: _____ Diagnosis/Disability(if applicable): _____
Street Address: _____Town_____zip_____
Home Phone: _____ Cell _____Email_____
Parent/Guardian/Contact Name: _____
Billing address (if different from part.)_____
School/ Institution Presently Attending: _____How did you hear about us: _____

Demographic Info. As a non-profit, Hidden Acres relies on funding sources that require this information.
Please check: Male ___ Female ___ Veteran yes ___ No ___
Household Income: __ below $15,000 __ $15,000-24,999 __ $25,000-39,999 __$40,000-54,999 __$55, 000+
Ethnicity: white __ African-Amer. __ Asian __ Nat. Amer. __ Hispanic__ Other _____

EMERGENCY INFORMATION - In the Event of an Emergency:
Preferred Medical Facility:_____
Primary Emergency Contact: _____ Relationship: _____
Phone: ( ) _____ Alternate name &ph: _____
Health Insurance Co: _____ Policy #:_____
Please list any food or other allergies, medications, or current health concerns: _____
_____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT & CONSENT PLAN
In the event that 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 Hidden Acres Therapeutic Riding Center to: Secure and retain medical treatment and transportation, if needed and release client records upon request to the authorized individual or agency involved in the medical emergency treatment. 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(s) listed cannot be reached.

Date: _____Consent Signature_____
Client, parent or legal guardian

PHOTO & PR RELEASE (please check one) ___ I hereby consent to and authorize, or ___ I do not consent to, nor do I authorize, the use and reproduction of any and all photographs and other audiovisual materials taken of me by Hidden Acres Therapeutic Riding Center, LLC for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the program.

Date: _____Signature: _____
Client, parent or legal guardian

LIABILITY RELEASE (Required): _____ (Part.Name) would like to participate in the Hidden Acres Therapeutic Riding Center, LLC Program. I acknowledge the risks and potential for risks of horseback riding and equine activities including grievous bodily harm. However, I feel that the possible benefits to myself/my child/my ward are greater that the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors, and administrators, waive and release forever all claims for damages against Hidden Acres Therapeutic Riding Center, LLC its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my child/my ward may sustain while participating in the Program from whatever cause including but not limited to negligence of these released parties.
The undersigned acknowledges that he/she has read this Registration and Release for in its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.

Date: _____ Signature: _____
Client, parent or legal guardian