Participant Liability & Release
Equest Center for Therapeutic Riding, Inc.

3777 Rector NE Rockford, MI 49341 Ph (616) 866-3066 Fax (616)863-6460 Email info@equestcenter.org Website: www.equestcenter.org

Circle one: RIDER VOL CAMP

REGISTRATION (please print) Today's Date: _____

Rider's Name: _____ Birthdate: _____ Age:_____

I identify my gender as (please circle): Man Woman Non-binary Other:_____ I prefer not to say

Address:_____ City:_____ County:_____

State: _____ Zip:_____ Email:_____(for Equest Center use only)

Phone numbers: Home: _____ Work:_____ Cell:_____ Other: _____

School or Institution (if applicable): _____ District:_____

Ethnicity:

_____White/Caucasian
_____Hispanic/Latino
_____Asian/Pacific Islander
_____ Native American/Alaskan Native
_____ Multiracial/Biracial
_____ African American/Black

Name (s) of parent(s) or Guardian:

_____ _____

Address: _____ City: _____

State: ____ Zip: _____ Home Phone: _____ Work/Cell _____

**** Person / party responsible for payment of rider tuition*** _____

Billing Address:_____City: _____

State:_____Zip: _____Relationship to rider_____ Phone _____

PHOTO RELEASE

I ☐ DO
☐ DO NOT

consent to and authorize the use and reproduction by Equest Center for Therapeutic Riding, Inc. of any and all photographs, videotape, audio tape and any other audio visual materials taken of me, or as applicable, my son, daughter or ward to promote or benefit the Equest Center for Therapeutic Riding, Inc. or recreational horseback riding, forever waiving any compensation for such use.

Printed Name:_____

Signature:_____Date:_____
(Rider, or Parent/guardian if rider is a minor)

Start Date: _____

RELEASE OF LIABILITY (please read carefully)

I,_____(client's name), would like to participate in one or more therapeutic or able-bodied equine activities conducted by the EQUEST CENTER FOR THERAPEUTIC RIDING, INC. ("EQUEST CENTER"), a Michigan non-profit corporation. Accordingly, in consideration of being on the premises of the Equest Center, being near horses at the Equest Center, and allowed to participate in equine activities at Equest Center, I acknowledge and agree as follows:

1. Equestrian activities are, by their very nature, a risk activity. Equestrian activities involve known and unanticipated risks which could result in physical or emotional injury, paralysis or permanent disability, death, and property damage. Risks include, but are not limited to, death, paralysis or serious injury as a result of falls while riding horses; broken bones, bruises and other bodily injuries caused by contact with horses, such as being bitten by, kicked by or stepped on by horses; medical conditions resulting from physical activity; and damaged clothing or other property. I understand such risks simply cannot be eliminated, despite the use of safety equipment, without jeopardizing the essential qualities of the activity.
2. On behalf of myself, my heirs, representatives and assigns and, as applicable, my ward or my minor child, I hereby assume full responsibility for and all risks associated with activities at the Equest Center. I fully understand there are risks and dangers associated with participation in equine activities which could result in serious bodily injury and/or death and/or property damage.
3. I release and discharge the Equest Center; including its officers, directors, employees, agents, instructors, contractors, riders, and other volunteers ("Released Parties"), from all lawsuits, actions, damages, claims and liability whatsoever, including, without limitation, death, and property damage or loss, which arise from or are in any way related to engaging in any activity at the Equest Center. I intend that my release and discharge includes all claims for damages resulting from the negligent act or omission ofthe Equest Center, including any Released Parties, excepting only the sole gross negligence or sole willful and wanton misconduct of these parties.
4. I further agree that this release and discharge of liability applies regardless of the legal cause of action on which my claim is based, including contract, strict liability, negligence, tort, or an alleged violation of the Michigan Equine Liability Act (PA 1994 No. 351).
5. I have adequate insurance to cover any injury or damage I may suffer or cause while participating in this activity, or else I agree to bear the costs of such injury or damage myself. I am willing to assume, and bear the costs of, all risks that may be created, directly or indirectly, by any physical condition that I have that may interfere with my safety while at the Equine Center.
6. I agree that this release of liability shall be governed by Michigan law and I acknowledge that the release exceeds the provisions of the Michigan Equine Liability Act because I am releasing the Released Parties for all damages, liability and causes of action, except only those for sole gross negligence or sole willful and wanton misconduct**. WARNING: I UNDERSTAND THAT UNDER THE MICHIGAN EQUINE ACTIVITY LIABILITY ACT, AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT INAN EQUINE ACTIVITY RESULTING FROM AN INHERENT RISK OF THE EQUINE ACTIVITY.**
7. I have read and understand this release of liability. My participation in this activity is purely voluntary and I elect to participate despite the risks. In addition, if at any time I believe that event conditions are unsafe or that I am unable to participate due to physical or medical conditions, then I will immediately discontinue participation. I hereby sign this release freely, knowingly and without coercion by anyone.

Date:_____

_____
Signature of Client, or if a minor, his/her parent or guardian

_____
Printed name of rider or if a minor, his/her parent or guardian.

Authorization for Medical Treatment
Equest Center for Therapeutic Riding, Inc.

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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 Equest Center Staff to:

1. Secure and retain medical treatment and transportation if needed.
2. Release records upon request to the authorized individual or agency involved in the medical emergency treatment.

Rider's name:_____Phone: _____

Address: _____

In case of emergency, contact:_____Relationship:_____

Home Phone:_____Work Phone:_____Cell: _____

OR if unavailable, contact:_____Relationship:_____

Home Phone:_____Work Phone:_____Cell: _____

Physician's name:_____Phone: _____

Preferred Medical Facility: _____

Health Insurance Co:_____Policy#: _____

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedures deemed "life-saving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Date:_____Consent Signature: _____
Client, Parent, or Guardian

Print Name: _____

Address: _____

Non-Consent Plan

I do not give my consent to 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 of emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

Non-consent Signature_____Date:_____
Client, Parent or Guardian

Print Name:_____ Phone: _____

Address: _____

Medical History & Physician Statement

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THIS PAPER MUST BE COMPLETED BY YOUR PHYSICIAN AND FAXED FROM THE DOCTORS OFFICE DIRECTLY TO EQUEST CENTER

Rider Name:_____DOB_____Height :_____Weight:_____
Address:_____
Primary Diagnosis:_____Date of Onset: _____
Secondary Diagnosis: _____
Past/Prospective Surgeries: _____
Medications:_____
Seizure Type:_____Controlled Y N Date of Last Seizure: _____
Shunt Present: Y N Date of Last Revision: _____
Special Precautions/Needs: _____
_____
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices: _____
For those with Downs Syndrome: AtlantoDens Interval X-rays, Date:_____Result + -
Neurologic Symptoms of AtlantoAxial Instability :_____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the PATH Intl. center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Name/Title:_____MD DO NP PA Other_____
Signature:_____Date:_____
Address: _____
Phone ( )_____ License/UPIN Number: _____

Therapeutic Riding Goals
Equest Center for Therapeutic Riding, Inc.

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Medications: (include prescription, over-the-counter; name, dose and frequency) _____

_____

_____

_____

_____

Describe your abilities/difficulties in the following areas (include assistance or equipment needed):

Physical Function (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding):

_____

_____

_____

_____

_____

Psycho/Social Function (Work/ School including grade completed, leisure interests, relationship- family structure, support systems, companion animals, fears/concerns, etc.)_____

_____

_____

_____

_____

_____

Goals (i.e. Why are you applying for participation? What would you like to accomplish?)

_____

_____

_____

_____

_____

Critical Links to the Community

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Many businesses and organizations will allow Non-Profit Organizations such as Equest Center to apply for specific grant monies if we serve an employee or a family member of an employee in our program, or if an individual is involved with Equest Center on a volunteer basis.

We would be most appreciative if you would share your connections in the community. It could have a major impact on our center. Thank You.

Today's Date: _____

Name:_____Rider? or Volunteer? (circle one)

Phone numbers: Home_____Work_____Cell_____other_____

Name (s) of parent(s), Grandparents, Guardian or other links to community:

Name	(Linked to) business/organization
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____