EQUEST CENTER
FOR THERAPEUTIC RIDING. INC.

# LIABILITY & RELEASE AGREEMENT FOR Equest Center RIDERS

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

TR AB VOL CAMP

## REGISTRATION (please print)

Today's Date: _____

Rider's Name:_____ Birthdate: _____Age _____

Address: _____ City: _____

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

Phone numbers Home _____ Work _____ Cell _____ other _____

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 _____

If Client presently attends a school or institution, please identify: _____

## PHOTO RELEASE

I ☐ DO
☐ DO NOT

consent to and authorize the use and reproduction by Equest Center 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 or recreational horseback riding, forever waiving any compensation for such use.

Printed Name:_____

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

**RELEASE OF LIABILITY** (please read carefully)

I, _____ (client's name), would like to participate in one or more therapeutic or able-bodied horseback riding classes or activities conducted by THE EQUEST CENTER FOR THERAPEUTIC RIDING, INC. (EQUEST CENTER), a Michigan non-profit corporation. In connection with such a program, I acknowledge that horseback riding is, by its very nature, a risk activity. Horses can behave unpredictably without warning and can cause injury, harm or death to persons around them. For example, a loud noise, sudden movement or unfamiliar person or animal can cause a horse to be frightened and buck, bite or kick. If I am around a horse in this condition, the horse could behave unpredictably and I could become injured as a result.
**MINDFUL OF THIS RISK, I NEVERTHELESS BELIEVE THAT THE BENEFITS OF BEING A RIDER AT THE EQUEST CENTER TO MYSELF, MY CHILD OR WARD ARE OF VALUE (continued).**

Accordingly, in consideration of being on the premises of the Equest Center, being near horses at the Equest Center, and allowed to ride at Equest Center, and intending to be legally bound, I agree:

1. On behalf of myself, my heirs, representatives and assigns and, as applicable, my ward or my minor child, I hereby release and discharge the Equest Center; including its officers, directors, employees, agents, instructors, contractors all lawsuits, actions, damages, claims and liability whatsoever. Including death, and property damage or loss, which arise from or are in any way related to engaging in volunteer activity at the Equest Center, including, but not limited to assisting therapeutic riding clients.

2. 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). I intend that my release and discharge includes all claims for damages resulting from the negligent act or omission of the Equest Center, including its officers, directors, employees, agents, instructors, contractors, riders and other volunteers, excepting only the sole gross negligence or sole willful and wanton misconduct of these parties.

3. 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 Equest Center and its related 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 IN AN EQUINE ACTIVITY RESULTING FROM AN INHERENT RISK OF THE EQUINE ACTIVITY.**

4. I have read and understand this release of liability. 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.

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# AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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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: _____

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# THERAPEUTIC RIDING
# Medical History & Physician's Statement

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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 NARHA 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: _____

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# THERAPEUTIC RIDING GOALS

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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?)**

_____

_____

_____

_____

_____

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# 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 |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |