Buddy Up! Horsemanship and THERAPEUTIC RIDING PROGRAM

Participant's Application

GENERAL INFORMATION:

Participant's Name:

Date of Birth: Age: Height: Weight:

Address: City: Zip:

Parent/Guardian:

Home Phone: Work Phone: Cell:

Email:

Diagnosis:

Seizures: Yes/No

Physician: Phone:

Referral Source:

How did you hear about Buddy Up! Horsemanship?:

PHOTO RELEASE (Circle either "I DO" or "I DO NOT")

I **DO**

I DO **NOT**

Consent to and authorize the use and reproduction by Buddy Up! Horsemanship and Therapeutic Riding Program of any and all photographs and other audio/visual materials taken of person/child for educational activities, medical progress, promotional material, exhibitions or for any other use for the benefit of the person/child or the program.

Signature: Date:

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Release and Hold Harmless Agreement

The undersigned assumes the unavoidable risks inherent in all horse related activities, including but not limited to bodily injury and physical harm to horse, rider, and spectator. In consideration, therefore, for the privilege of riding and or working around horses with Buddy Up! Horsemanship and Therapeutic Riding Program operating at Scatter Creek Stables, 4945 165th Lane SW, Rochester, WA, the undersigned does hereby agree to hold harmless and indemnify Buddy Up! Horsemanship and Therapeutic Riding Program and Scatter Creek Stables and further release them from any liability or responsibility for any accident, damage, injury, illness to the undersigned or to any family member or spectator accompanying the undersigned on the premises.

Name (please print):

Address:

Phone Number:

Email Address:

Cell Phone:

Signature (if under 18, parent or guardian signature):

Date:

Witness:

Date:

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Authorization for Emergency Medical Treatment Form

_____Participant _____ Staff _____Volunteer

Name: DOB: Phone:

Address:

Physician's Name: Medical Facility:

Allergies to medication:

Current medications:

In event if an emergency, contact:

Name: Relationship: Phone:_____

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, I authorize Buddy Up! Therapeutic Riding Program to:

1. Secure and retain medical treatment and transportation if needed; and/or
2. Release client records upon request to the authorized individual or agency involved in the Emergency Medical Treatment.

Consent Plan (Sign either consent or non-consent – not both)

The authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure of receiving services or while being on the property. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Consent Signature: Date:

Non-Consent Plan (Sign either consent or non-consent – not both)

I do not give my consent for emergency medical treatment/aid in case of illness or injury during the process of receiving services or while being on the property. In the event emergency treatment/aid is required, I wish the following procedures to take place (specify):

Non-Consent Signature: Date: