At Divine Equine Therapeutic Riding Center, children and adults with disabilities will excel beyond their abilities through the help of a horse and the dedication of a professional and caring community.

REGISTRATION AND RELEASE FORM LIABILITY RELEASE

Client Information

Name: _____

Date of Birth: _____Gender: _____Height/Weight: _____/_____

Diagnosis: _____Date of Onset: _____

Address: _____City: _____

County: _____State: ____ Zip Code: _____ Email: _____

Clients Occupation/Employer or School/Grade: _____

Primary Phone best way to reach you: _____ Call or text

Parent /Guardian Information (If Applicable):

Father's Name _____ Mother's Name: _____

Fathers Primary Phone: _____ Mother's Primary Phone: _____

Father's Email: _____Mother's Email: _____

Father's Occupation: _____ Mother's Occupation: _____

Alternate contact Name and Relation to client: _____

Alternate phone: _____ Email: _____

Guardian/Caregiver Information (If Applicable):

Name: _____ Phone: _____

Address_____ City _____ Zip _____

POLICY OF CONFIDENTIALITY

I agree to respect and observe privacy and confidentiality of the participants, volunteers and donors of Divine Equine Therapeutic Riding Center Therapeutic Riding Center and not discuss or disclose any sensitive information about any person or their family. Participant Signature 18 years or older:

Client's Name: (Please print First and Last) _____

Date: _____Signature: _____

Client, Parent, or Guardian

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(Print Clients First and Last Name) _____ would like to participate in the Divine Equine Therapeutic Riding Center's Program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Divine Equine Therapeutic Riding Center, its Board of Directors, Instructors, Therapists, Aides, Volunteers, and or Employees for any and all injuries and /or losses I/my son/my daughter/ my ward may sustain while participating in Divine Equine Therapeutic Riding Center.

WARNING – Under Texas law (Chapter87, Civil Practice and Remedies Code), an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities.

Date: _____ Signature _____

Client, Parent, or Guardian

Photo Release: (Please indicate your preference by signing your consent or non-consent)

I authorize the use and reproduction by Divine Equine Therapeutic Riding Center, of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the program.

I CONSENT to use photographs

Date: _____Consent Signature: _____

Client, Parent, or Guardian

I DO NOT CONSENT to use photographs

Date: _____ Non-Consent Signature_____

Client, Parent, or Guardian

Divine Equine Policy is to Protect and preserve the confidentiality of all Protected Information and DETRC will not use or disclose Protected Information without authorization unless disclosure is required by law. Protected Information includes (but is not limited to) Names, mailing, address, telephone numbers and email addresses.

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FOR Clients

CONSENT PLAN

Clients' Name: _____Phone: _____

Address: _____

In the event of an emergency:

1.Contact: _____Relationship: _____ Phone: _____

2Contact: _____ Relationship: _____ Phone: _____

Physician's Name: _____Phone: _____

Preferred Medical Facility: _____Health Insurance Co: _____ Policy#: _____

Allergies, Current MEDS: _____

CONSENT PLAN 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 center, I authorize Divine Equine Therapeutic Riding Center to:

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

□ **I give consent** This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked in the persons listed above are unable to be reached.

Date: _____ Consent Signature: _____

Client, Parent, or Guardian

~~~ OR ~~~ NON-CONSENT PLAN (Only for Persons 18 or Older)

□ **I do not give consent** for emergency medical treatment/aid in the event of illness or injury during the process of receiving services, or while being on the property of Divine Equine Therapeutic Riding Center. In the event emergency treatment/aid is required, I wish the following procedures to take place. _____

Participant Name: (Please print first and Last) _____

Date: _____Signature: _____

Client, Parent, or Guardian

DATE OF LAST TETANUS SHOT: _____
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