The Medicine Horse Center

Equine Assisted Therapies
P.O. Box 1074, Mancos, CO 81328
Tel: 970-533-7403 Fax: 970-533-7405

Instructions for Equine Experiential Learning Application Youth Enrichment Programs

The following forms are to be filled out by the following persons:

Page 1 – Instructions

Page 2 – Client or Parent/Guardian

Page 3 – Client or Parent/Guardian

Page 4 – Client or Parent/Guardian

Page 5 – Client or Parent/Guardian

Page 6 – Client or Parent/Guardian

All forms must be completed in their entirety and mailed or faxed to the Medicine Horse Center Headquarters a minimum of one week prior to the first session:

Medicine Horse Center
P.O. 1074
Mancos, CO 81328

Or fax: 970-533-7405

For questions, please call: 970-533-7403

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Participant's Registration and Release Form

Client:_____Date of Birth:_____ Weight:_____lbs

For the safety of our horses, there is a **client weight restriction of 180 lbs.**

Street:_____City:_____State:_____Zip:_____

Phone: Home:_____Work _____Emergency:_____

Parent/Guardian Name:_____

Address/Phone:_____

School or institution presently attending:_____

In case of emergency contact:_____Phone:_____

contact:_____Phone:_____

Photo Release

I hereby consent to and authorize the use and reproduction by The Medicine Horse Center of any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Signature:_____ Date:_____

(Participant or Parent/Guardian)

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Participant Liability Release Agreement

I, _____(Client's Name) would like to participate in The Medicine Horse Center's Equine Assisted Therapy Programs. I acknowledge the risks and potential for risks of being around horses. However, I feel that the possible benefits to myself/ my child/ 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 The Medicine Horse Center, 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 Medicine Horse Center's Therapeutic Riding and Equine Rehabilitation Program.

UNDER COLORADO LAW, AN EQUINE ACTIVITY SPONSOR IS NOT LIABLE FOR AN INJURY TO, OR THE DEATH OF, A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERANT RISKS OF EQUINE ACTIVITIES THAT ARE OBVIOUS AND NECESSARY, PURSUANT TO 13-21-119 COLORADO REVISED STATUES.

Signature:_____ Date:_____

(Participant or Parent/Guardian)

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Participant's Authorization for Emergency Medical Treatment

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 ***The Medicine Horse Center*** to:

_X_ Secure and retain medical treatment and transportation if needed.

_X_ Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment at my expense.

I hold the Medicine Horse Center harmless for any expenses incurred in my interests.

Name:_____ Phone:_____

Address:_____

Emergency Contact: _____ Phone: _____

Physician's Name and Phone:_____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Phone: _____

Policy #: _____ Group #: _____

Consent Plan

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 below is unable to be reached.

Print Name: _____ Phone: _____

Address:_____

Consent Signature:_____ Date: _____

(Participant or Parent/Legal Guardian)

Non-Consent Plan

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

_____

_____

_____

_____

_____

Non-Consent Signature:_____ Date: _____
(Participant or Parent/Legal Guardian)

Print Name: _____ Phone:_____

Address:_____

Please note any known allergies or health concerns that Medicine Horse Center should be aware of:

_____

_____

_____

_____

_____