MEDICINE HORSE CENTER
Horses Helping People

P.O. Box 1074/40700 Road J, Mancos, CO 81328
Tel: 970-533-7403 info@medicinehorsecenter.org

Adult Registration and Release Form

Participant Name : _____ DOB: _____

Address:_____City:_____State:_____Zip_____

Email: _____

Cell Phone: _____

In case of emergency contact: _____

_____

Photo Release

I hereby consent to and authorize the use and reproduction by Medicine Horse Center of any and all photographs and any other audiovisual materials taken of me/my ward for promotional printed and/ or digital purposes (including social media and web site), educational activities or for any other use for the promotion of Medicine Horse Center and its programs.

Signature:_____ Date:_____

Participant Liability Release Agreement

I,_____,(Parent/Guardian's Name) would like my child to participate in Medicine Horse Center's Equine Assisted Learning Programs. I acknowledge the risks and potential for risks of being around horses, however, I feel that the possible benefits to my child 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 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 Medicine Horse Center's programs.

Please note:

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 STATUTES.

Signature:_____Date: _____

Participant 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 ***Medicine Horse Center*** to:

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

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

Emergency Contact:_____ Phone: _____

Physician's Name and Phone: _____

Preferred Medical Facility: _____

Health Insurance Co.:_____ Policy #: _____

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the attending physician(s). This provision will only be invoked if the emergency contact person above is unable to be reached.

Consent Signature:_____ Date: _____

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: _____

Known Allergies or Health Concerns:_____

Medicine Horse Center: Therapeutic Riding & Equine Rehabilitation
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