

**Trinity Equestrian Center**  
**Healing with Horses**

S5300 State Road 37  
Eau Claire, WI 54701  
(715) 835-4530  
trinity-ec.com



**Client Release Form**

Client \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ School presently attending \_\_\_\_\_

Parents or Guardian \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Parent or other contact person home & work phone \_\_\_\_\_

**Liability Release (REQUIRED)**

In return for being allowed to use Trinity Equestrian Center 's therapeutic riding program, including its facilities, horses and equipment, where applicable for horseback riding and other horse related activities, I/ my son/my daughter/my ward \_\_\_\_\_ (Client's Name) agree to abide by all rules and regulations of Trinity Equestrian Center now in effect or later adopted. In addition, I hereby agree to assume all responsibility and risk for me and from my son's/my daughter's/my ward's participation in activities at Trinity Equestrian Center. I further agree to hold Trinity Equestrian Center, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees free and harmless from all damages or liability for any injury to person or property arising as a result of the use of facilities, horses and/or equipment owned by or leased to Trinity Equestrian Center, including any injury caused by their negligence.

I am aware of the significant risks of injury that horseback riding and horse-related activities may cause to myself/my son/my daughter/my ward, however I feel that the possible benefits to myself/my son/my daughter/my ward are greater than and out weigh the risk assumed. By signing this agreement, I am assuming all risk and do hereby understand that horses are animals, not subject to any guarantee of reliability. Therefore, I agree to release, indemnify and hold harmless Trinity Equestrian Center, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees from all liability they may incur.

In accordance with the Wisconsin Law relating to the limitation of civil liability regarding equine activities: "NOTICE: A person who is engaged for compensation in the rental of equines or equine equipment or tack or in the instruction of a person in the riding or driving of an equine or in the being a passenger upon an equine is not liable for the injury or death of a person involved in the equine activities resulting from the inherent risks of equine activities, as defined in section 895.481(1)(e) of the Wisconsin Statutes."

Date \_\_\_\_\_ Signature \_\_\_\_\_

Client, Parent or Guardian

**Photo Released (we appreciate your consideration of this!)**

I do       I do not

Consent to and authorize the use and reproduction by Trinity Equestrian Center of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional materials, educational activities, exhibitions or for any other use for the benefit of the program.

Exceptions \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

Client, Parent or Guardian

**Authorization for Emergency Medical Treatment**

**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 the agency, I authorize Trinity Equestrian Center to:

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

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.

In the event, I \_\_\_\_\_ can not be reached, please

Contact \_\_\_\_\_ Phone \_\_\_\_\_

Contact \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Name \_\_\_\_\_

Preferred Medical Facility \_\_\_\_\_

Health Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Date \_\_\_\_\_ Consent Signature \_\_\_\_\_

Client, Parent or Guardian

Print Name \_\_\_\_\_ Phone \_\_\_\_\_

**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 procedures to take place \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_ Non-Consent Signature \_\_\_\_\_

Client, Parent or Guardian

Print Name \_\_\_\_\_ Phone \_\_\_\_\_