Trinity Equestrian Center
Healing with Horses
S5300 State Road 37, Eau Claire, WI 54701
(715) 835-4530 ~ www.trinity-ec.com

Client/Visitor Participation Release

Name_____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 Equine Therapy Programs, including its facilities, horses and equipment or any privately owned horses for horseback riding and other horse related activities, I, my family member or my ward_____ (Participant'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, my family member or 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 or all Owner's of privately owned horses, 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 or Owners or any privately owned horses, 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, family member or my ward, however I feel that the possible benefits to myself, my family member or 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 and all Owners of privately owned horses, 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_____