

TRI-STATE THERAPEUTIC RIDING SPECIAL EVENT LIABILITY FORM

DATE: \_\_\_\_\_ Name: \_\_\_\_\_ Age (if under 18): \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email: \_\_\_\_\_ Name of School (if applicable): \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

**In Case of Emergency**

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_ Hospital: \_\_\_\_\_

In case of emergency, I give Tri-State Therapeutic Riding Center permission to secure medical treatment including x-ray, surgery, hospitalization, and medication for me.

Rider Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent Signature (if under 18): \_\_\_\_\_ Date: \_\_\_\_\_

**Photo Release**

I consent to and authorize the use and reproduction by Tri-State Therapeutic Riding Center of any and all photographs and any other audio-visual material taken of me for promotional material, education activities, exhibitions, or for any other use for the benefit of the program.

Rider Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent Signature (if under 18): \_\_\_\_\_ Date: \_\_\_\_\_

**Liability Release**

I acknowledge the risks and potential for risks of a program involving horses. However, I feel that the possible benefits are greater than the risk assumed. I hereby, intending to be legally bound for myself, my ward or administrators, waive and release forever all claims for damages against Rainbow Therapeutic Riding, its Board of Directors, instructors, therapists, volunteers, interns, and/or employees for any and all injuries and/or losses I may sustain while participating at Tri-State Therapeutic Riding Center or during an off-campus function.

Rider Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent Signature (if under 18): \_\_\_\_\_ Date: \_\_\_\_\_

**Confidentiality Statement**

Tri-State Therapeutic Riding Center will preserve the right of confidentiality for all individuals in its program. The staff and volunteers will keep confidential all medical, social, personal, and financial information regarding a person and their family.

I understand and will observe the confidentiality policy of Tri-State Therapeutic Riding Center.

Rider Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent Signature (if under 18): \_\_\_\_\_ Date: \_\_\_\_\_

