



REGISTRATION AND RELEASE INFORMATION

Participant: _____ Date of Birth: _____ Age: _____
Street: _____
City: _____ County: _____ Zip Code: _____
Home Phone: _____ Work/Cell Phone: _____
School or Institution presently attending: _____
Primary Email (used for newsletters, billing, etc.): _____

- Participant is a (circle one): minor adult w/a legal guardian independent adult
(Only parents, legal guardians or independent adults may sign these forms.)
- Please name any caregivers/phone numbers who may transport or be responsible for Participant: _____

For demographic data only, please indicate participant's ethnic background. Check any that apply:
Caucasian Asian Hispanic/Latino African American Native American Other

.....

Parent or Guardian Name: _____ Occupation: _____
Employer: _____ Work Phone: _____
Cell Phone: _____ Email: _____
Other Parent or Guardian Name: _____ Occupation: _____
Employer: _____ Work Phone: _____
Cell Phone: _____ Email: _____
Parent or Guardian Home Address (if different): _____
Home Phone: _____

Consent and Waiver

I hereby request that the Participant named above be accepted into the horseback riding and driving program operated by Fieldstone Farm Therapeutic Riding Center (TRC), an Ohio non-profit organization. I acknowledge that Fieldstone Farm TRC has fully explained to me the scope of the equine program, including the potential for injury which can occur from riding, driving or caring for horses. Because of the potential benefits of Fieldstone Farm TRC's program, I hereby waive any claim which I or the Participant may have against Fieldstone Farm TRC, its Trustees, employees or volunteers arising out of any injury which the Participant may sustain while involved in the mounted or unmounted equine program at Fieldstone Farm.

Date: _____ **Signature:** _____
Circle one: (Independent adult participant or parent or legal guardian)



PHOTO RELEASE

For valuable consideration, the receipt of which from Fieldstone Farm Therapeutic Riding Center is hereby acknowledged, the undersigned hereby grants to Fieldstone Farm permission to take, or have taken, still and moving photographs, videos and films including television pictures of myself or my daughter/son/ward (strike out inapplicable words), _____ and consents and authorizes

(Participant name, please print)

Fieldstone Farm, its advertising agencies, news media, and any other persons involved with Fieldstone Farm and its programs, to use and reproduce the photographs, films, videos and pictures and to circulate and publicize the same by any means deemed appropriate by Fieldstone Farm, including without limitation newspapers, television media, brochures, pamphlets, instructional materials, books and clinical materials.

No inducements or promises have been made to me to secure my signature to this release other than the intention of Fieldstone Farm to use or cause to be used such photographs, films, videos and pictures for the primary purpose of promoting and aiding Fieldstone Farm and its programs.

___ I DO consent

___ I DO NOT consent

Date: _____ Signature: _____

Circle one: (Independent adult participant or parent or legal guardian)

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Participant's Name: _____ Phone: _____

Address: _____ City/Zip: _____

Emergency Contacts:

In case of emergency, please contact: _____ Phone: _____

Other Contact: _____ Phone: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Co: _____

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM. Please note on the back of this form any medical considerations including allergies (bee stings, asthma, etc.), conditions requiring regular physician's care, and prescribed medications taken regularly.

AUTHORIZATION

The undersigned hereby grants to a staff member of Fieldstone Farm the authority to disclose and/or receive any information pertaining to the health care of the participant, while participating in Fieldstone Farm programs, and to make health care decisions on their behalf in the event of a medical emergency which renders them incapable of obtaining or disclosing such information. The term "health care" and "health care decisions" as used in this form shall have the meanings set forth in Ohio Rev. Code sections 1337.11 through 1337.17.

___ I DO consent

___ I DO NOT consent*

Date: _____ Signature: _____

Circle one: (Independent adult participant or parent or legal guardian)

***In the event that consent is not authorized and in order for services to be rendered, an authorized person must remain on the premises and demonstrate proof of authorization, to be kept on file.**