Equine Tranquility Wellness Center

"Promoting Education, Personal Development and Communication Through Equine Assisted Activities"

REGISTRATION AND RELEASE FORM

Participant's Name:_____ Date of Birth:____/____/____ Age:_____
Weight: _____ Height: _____ Disability(ies):_____
School or Institution Presently Attending:_____ Teacher:_____
Primary Contact Name:_____Relationship:_____
Best Number To Contact at:_____ Email address:_____
Mailing Address:
Street_____ City:_____ State:_____ ZIP:_____
Home phone:_____ Cell Phone:_____ Fax:_____
Employer:_____ Work phone:_____ OK to contact at work:( ) yes ( ) no

PHOTO RELEASE

_____ I hereby consent to and authorize
_____ I do not consent to, nor do I authorize

The use and reproduction of any and all photographs and other audiovisual materials taken of me/participant by Equine Tranquility Wellness Center for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the program.

Date:_____ Signature:_____
(Client, Parent, or Legal Guardian)

LIABILITY RELEASE (Required)
_____(Name) would like to participate in the Equine Tranquility Therapeutic Riding Program. I acknowledge the risks and potential for risks of horseback riding and related equine activities, including grievous bodily harm. However, I feel that the possible benefits to myself/my child/my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors, and administrators, waive and release forever all claims for damages against Equine Tranquility Wellness 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 the Program from whatever cause including but not limited to the negligence of these released parties.

The undersigned acknowledges that he/she has read this Registration and Release Form in its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof

Date:_____ Signature:_____
(Client, Parent, or Legal Guardian)

Mailing address: 1180 Ringwood Ave. ● Pompton Lakes, NJ 07442
Barn address: Windsor Astoria Farm ● 45 Hamilton Rd. ●. Greendell, NJ 07839
Contact: Colleen O'Dea, CTRI; colleengodea@aol.com, 201-970-3400, Fax 973-839-6337

Equine Tranquility
Wellness Center

"Promoting Education, Personal Development and Communication Through Equine Assisted Activities"

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

_____Participant _____Staff _____Volunteer

Name:_____DOB:_____Phone:_____
Physician's Name:_____Preferred Medical Facility:_____
Health Insurance Co:_____Policy #:_____
Current Allergies, Medications, and Health Concerns: _____
_____
_____

In the event of an emergency:
Emergency Contact 1:_____Relation:_____
Home Ph:_____ Work Ph: _____ Cell Ph:_____
Emergency Contact 2:_____Relation:_____
Home Ph:_____ Work Ph: _____ Cell Ph:_____

In the event that 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:
EQUINE TRANQUILITY WELLNESS CENTER to:

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

CONSENT PLAN
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(s) listed cannot be reached.**

Date:_____Consent Signature:_____
Client, Parent, or Legal Guardian

NON-CONSENT PLAN
I do not give 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 (please give details below):

_____
_____

Date:_____Non-Consent Signature:_____
Client, Parent, or Legal Guardian