



NONRIDER PARTICIPANT LIABILITY RELEASE

(Please Print)

Participant Name: _____

Street Address: _____ **City:** _____

State: _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email:** _____

I _____ (PARTICIPANT NAME) am participating in a Pony Power Therapies, Inc. program. I acknowledge the risks and potential for risks associated with being around horses in a barn environment. However, I feel that the possible benefits to my self are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Pony Power Therapies, Inc., its board of directors, instructors, therapists, volunteers and/or employees for any and all injuries and/or losses I may sustain while participating in Pony Power Therapies, Inc.

___ I am interested in receiving periodic communications/updates from Pony Power.

___ I am NOT interested in receiving periodic communications/updates from Pony Power.

Date: _____

Participant(over 18)/Parent/Guardian(Print): _____

Participant(over 18)/Parent/Guardian Signature: _____



PHOTO RELEASE

Please select and sign one of the options below:

I DO

Consent to and authorize the use and reproduction by Pony Power Therapies of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____

Client, Parent or Legal Guardian
Signed in the presence of center staff

Date: _____

I DO NOT

Consent to and authorize the use and reproduction by Pony Power Therapies of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____

Client, Parent or Legal Guardian
Signed in the presence of center staff

Date: _____



AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Please select one:

Participant Staff Volunteer

Name: _____ Phone: _____ Cell Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

DOB _____ Gender: Male Female

Ambulatory: Yes With Assistance No

Diagnosis (if applicable): _____

Physician Name: _____ Phone: _____

Primary Therapist Name: _____

Primary Therapist Phone: _____

Preferred Medical Facility _____

Health Insurance Provider _____ Policy # _____

Allergies to medications _____

Current Medications _____

In the event of Emergency, contact:

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

In the event emergency medical aid/ treatment are required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Pony Power 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.

Please sign one option:

1. 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) above is unable to be reached.

Date _____ Signature _____

Client (over 18), Parent or Legal Guardian

2. Non-Consent Plan*

I do not give my consent for emergency medical treatment/and in the case of illness or injury during the process of receiving services or while being on the property of the agency.

Parent or legal guardian will remain on site at all times during equine assisted activities

In the event emergency treatment/aid is required I wish the following procedure to take place

Date _____ Signature _____

Parent or Legal guardian

* This option means parent or legal guardian must remain on site during all activities.