C.H.U.M. Therapeutic Riding Inc. - Children and Horses United in Movement

_____Rider and/or _____Volunteer Registration and Emergency Treatment

Date_______________

New rider____ Return rider____ School attending____

No individual can be accepted for riding instruction until this form has been completed by his/her parent(s) or guardian or by the individual if he/she is a legally competent adult age 18 or over. Riding instructions will be under strict supervision, and although every effort will be made to avoid any accident, **no liability** can be accepted by any of the individuals or organizations concerned or by C.H.U.M. Therapeutic Riding Inc., its personnel, or affiliates.

Rider name____

Date of birth____________________

Address____City________________________State___________

ZIP___________Phone________________________________Diagnosis____

____

Date ofonset____Age_______________ Height_________ Weight__________

Parent/guardian name____

Phone_________________________Address____

City________________________State__________ZIP__________

Previous Riding Experience____

Physician's Name____Phone___________________

Address____City________________________State___________

ZIP__________

Person who should be contacted in case of emergency in absence of parent or guardian:

Name____Phone___________________

Relationship__________________

Authorization for Purpose of Providing Medical Treatment

You are being asked to complete this form to give an appropriate medical facility permission to treat

____ (rider's name) for minor injury or medical problems. In the event of serious injury or illness, you will be contacted; treatment will proceed before contacting you only if the situation is urgent and does not permit delay.

Preferred medical facility____

Is there a medical condition requiring special precautions or treatment? Yes____ No____

If yes, please describe____

Medications being used: Yes____ No____ If yes, please list dosage and description__________________________________

In case of medical emergency, the undersigned authorizes the C.H.U.M. Therapeutic Riding Inc. instructor and/or program coordinator to seek any medical and/or surgical treatment necessary for the care of _____________________________________ who is participating in the C.H.U.M. Therapeutic Riding Inc. program with parent/guardian permission and with the permission of his/her physician ____. I understand that **no liability** can be accepted by any individual or organization concerned with this program in the event of any accident which may occur.

Health insurance:

Name of policyholder ____

Name of company____

Policy number __________________________________

Name of policyholder's employer____

The above designated person(s) is (are) hereby authorized to incur medical costs necessary to provide medical treatment for said participant for which we shall be fully responsible. We also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Signiture____Date___________________________

Witness____