THE HOPE CENTER USA

The Hope Center
2019 E Harvest Circle
Perryville, MO 63775
573-517-6004

The Young Equestrian Program Application

Name: _____

Address: _____

Parent/Guardian (s): _____

Phone: Home: _____
Cell: _____
Work: _____
E-Mail: _____

Participant Date of Birth: _____ Gender: M or F

Height: _____ Weight: _____ (used to determine equipment and horse)

Any Known Medical Illness or Disability: _____

Does the participant have any horse riding experience: _____

Diagnosis: _____

Counselor/Psychiatrist: _____, Phone number: _____

I give consent for the Hope Center to contact and communicate (share and receive information) with the referring agent in regards to diagnosis, treatment goals, and safety concerns.

Parent/Guardian Signature: _____

Do you have any goals that you would like to see addressed while participating in the Young Equestrian Program?

_____

_____

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Participants Authorization for Emergency Medical Treatment Form

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while on the property of the agency, I authorize The Hope Therapeutic Horsemanship Center to:

1. secure and retain medical treatment and transportation if needed
2. release client records upon request to authorized medical personnel

Participants name:_____ phone: _____
Address:_____
In the event I cannot be reached contact: _____phone:_____
or: _____phone:_____
Physicians name: _____ phone:_____
Preferred Medical Facility:_____
Health Insurance Co.:_____ Policy #:_____

Consent Plan

This authorization includes x-rays, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. The provision will only be invoked if the person below is unable to be reached.
Date: _____ Consent Signature: _____
Participant if 18 or older, parent or guardian
Print name: _____ phone: _____
Address: _____

Non-Consent Plan

I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while on the property of the agency. In the event emergency aid/treatment is required, I wish the following procedures to take place:

_____
_____

Date: _____ Non-consent signature:_____
Participant if 18 or older, parent or guardian
Print name:_____ phone:_____
Address:_____

This form is valid for a period of one (1) year from date signed.
A copy of the completed medical history should be attached to this form.

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Participant Release and Indemnification Agreement

I acknowledge and understand the inherent risks of Horse activities and that horsemanship experiences can result in injury and even death. In consideration for being accepted into the The Hope Therapeutic Horsemanship Center and for the benefits I receive from participating in the program, I, _____, (participant if 21 or older, parent or guardian) hereby consent to assume the risks of _____, (participant's) participation in the horsemanship program sponsored by The Hope Therapeutic Horsemanship Center

Accordingly, I hereby, intending to be legally bound, for myself, my heirs and assigns, executors, or administrators, waive and forever release, acquit, discharge and hold harmless, The Hope Therapeutic Horsemanship Center, the owners of the facilities and properties on which The Hope Therapeutic Horsemanship Center conducts its therapeutic horseback riding program, including, but not limited to Rick and Claire Schemel, the officers, directors, agents, employees, representatives, therapists, instructors, and volunteers, of The Hope Therapeutic Horsemanship Center and any other person associated with The Hope Therapeutic Horsemanship Center therapeutic horseback riding program, and the successors and assigns of each of them, from all manner of claims, demands and damages of every kind and nature whatsoever I may now or in the future have against these parties on account of any losses or personal injuries, physical or mental condition, known or unknown to myself and the treatment thereof, as a result of, or in any way connected with the The Hope Therapeutic Horsemanship Center therapeutic horseback riding program, or growing out of acts of omission or caused by negligence or in any way incidental to the The Hope Therapeutic Horsemanship Center therapeutic horseback riding program.

WARNING

Under Missouri law, a Horse professional is not liable for any injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities pursuant to the Revised Statutes of Missouri.

Date:_____ Signed:_____
Participant if 21 or older, parent or guardian

Witnesses:_____

_____

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Photo/Video Release

Name of Child: _____

Name of Parent: _____

There are times when photos or videos may be taken of your child during a lesson and may be posted on the Hope Center Facebook Page, in the paper or printed out and used for advertisements.

___ I give my permission for these photos or videos to be used.

___ I do not give my permission for any photos or videos to be used of my child.

Parent Signature: _____ **Date:** _____