Visitor Release of Liability

Name:		Date:	
Address:		City:	Zip:
Date of Birth:	Home Phone:	Cell Phone:	
Email Address:			
Employer/School:		Work Phone:	
Emergency Contact		Phone:	

Visitor Liability Release
I understand that the information provided above is accurate to the best of my knowledge. I know of no reason why I should not participate in this center's program. As a visitor at Special Equestrians, Inc, I acknowledge the risks and potential for risks of a horseback riding program. However, I feel that the possible benefits to me are greater than the risk 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 Special Equestrians, Inc., its board of directors, instructors, therapists, volunteers and/ or employees, and Indian Springs School, its board of directors, volunteers and/ or employees for any and all injuries and or losses I may sustain while participating in Special Equestrians, Inc.

Signature: ________________________________ **Date:** ________________
(Visitor, parent/guardian if under 19)

SIGN AND RETURN TO SPECIAL EQUESTRIANS

Photo Release

I ☐ **DO** ☐ **DO NOT** consent to and authorize the use and reproduction by Special Equestrians, Inc. of any and all photographs and any other audio-visual materials taken of me for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

Signature: ________________________________ **Date:** ________________
(Visitor, parent/guardian if under 19)

Confidentiality Policy

Special Equestrians Inc. shall preserve the right of confidentiality for all individuals in our program. The visitors will keep all medical, social, referral, personal and financial information regarding all persons and their family confidential and will not discuss medical, personal, or financial information with anyone at the facility or away from it. A participant may not be competent to give consent for disclosure of medical or sensitive information due to age or disability incapacity. Children under 18 do not have legal authority to consent to disclosure.

Signature: ________________________________ **Date:** ________________
(Visitor, parent/guardian if under 19)

Authorization for Emergency Medical Treatment

Consent Plan
In the event 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 Special Equestrians, Inc. to:

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

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 below is unable to be reached.

Allergies:		Medications:	

Print Name: ________________________________

Consent Signature: ________________________________ **Date:** ______________
(Visitor, parent/guardian if under 19)

Non-Consent Plan *(Only complete this portion if you did not complete the Consent Plan)*

I **DO NOT** give my 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:
____

Print Name: ________________________________

Non-Consent Signature: ________________________________ **Date:** ______________
(Visitor, parent/guardian if under 19)

1215 Woodward Drive • Indian Springs, Alabama 35124 • (205) 987-WHOA • www.specialequest.org