



Participant's Application

GENERAL INFORMATION

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____

Phone: _____ E-mail _____ Alternative #: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

Phone: _____

How did you hear about the program? _____

Goals (i.e. Why are you applying for participation? What would you like to accomplish?)

Signature: _____ Date: _____



Authorization for Emergency Medical Treatment Form

Participant Staff Volunteer

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

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 _____ to:
(Center's Name)

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) above is unable to be reached.

Date: _____ Consent Signature: _____

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

Non-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.

- 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: _____ Consent Signature: _____

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



Chariot Riders Inc. Monmouth County
A therapeutic riding academy for everyone!

220 Adelpia Road
Farmingdale, NJ 07727
(732) 657-2710

Client Liability Release

I/my son/my daughter/my ward would like to participate in the **Chariot Riders Inc.** program(s). I acknowledge the risks and potential for risks of engaging in horseback riding activities as well as activities in close proximity to horses. However, I feel that the possible benefits to me/my son/my daughter/my ward are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors and/or administrators, waive and release forever all claims for damages against **Chariot Riders Inc.**, its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses that I/my son/my daughter/my ward may sustain while participating in activities at **Chariot Riders Inc.**

Print name: _____ Date: _____

Caregiver/Client/Legal guardian consent signature: _____

Photo Release

I hereby: (choose one)

consent to and authorize or **do not consent** to or authorize

the use and reproduction by **Chariot Riders 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.

Print name: _____ Date: _____

Caregiver/Client/Legal guardian consent signature: _____