



**Maryland Therapeutic Riding, Inc.**  
 P.O. Box 6477, Annapolis, MD 21401  
 410.923.1187 (phone) 410.923.1432 (fax)  
[www.horsethatheal.org](http://www.horsethatheal.org)



## Authorization for Emergency Medical Treatment Form

### Recreational Riding Participant

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:

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*

### 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*



**Maryland Therapeutic Riding, Inc.**  
 P.O. Box 6477, Annapolis, MD 21401  
 410.923.1187 (phone) 410.923.1432 (fax)  
[www.horsethatheal.org](http://www.horsethatheal.org)



## Recreational Rider Information Form and Health History

### General Information:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Address: \_\_\_\_\_

Recent medical tests: \_\_\_\_\_

Last Tetanus Shot: \_\_\_\_\_ Tuberculosis test Date: + or -- \_\_\_\_\_  
*(Consult your physician or local health department if you are not up to date with these shots/tests)*

### Health History

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries, or lifestyle changes.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Allergies: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Maryland Therapeutic Riding, Inc.**  
P.O. Box 6477, Annapolis, MD 21401  
410.923.1187 (phone) 410.923.1432 (fax)

[www.horsethatheal.org](http://www.horsethatheal.org)



## **Recreational Rider Information Form and Health History**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### **Photo Release:**

I DO  
DO NOT

Consent to and authorize the use and reproduction by Maryland Therapeutic Riding 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 center.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Confidentiality Agreement:**

I understand that all information (written and verbal) about participants at this NARHA center is confidential and will not be shared with anyone without the expressed written consent of the participant.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Maryland Therapeutic Riding, Inc.**  
P.O. Box 6477, Annapolis, MD 21401  
410.923.1187 (phone) 410.923.1432 (fax)  
[www.horsethatheal.org](http://www.horsethatheal.org)



## **Recreational Riding Release of Liability Form**

**Name of Participant** \_\_\_\_\_

Maryland Therapeutic Riding, Inc., (MTR) its officers, employees and agents will not be responsible for any damages to person, animal or property at the MTR riding center or its grounds, nor will they be responsible for any property lost or destroyed. The undersigned volunteer/rider/parent/guardian hereby releases MTR, its officers, employees and agents from any and all liability, claims and damages whatsoever (including costs, expenses and attorney's fees) that might result from damages, injuries, or losses to the person or property during, or in connection with, or arising out of any show, clinic, event or function, whether or not such damages, injuries or losses result directly or indirectly from the negligent act or omission of such released parties.

**WARNING: UNDER MARYLAND LAW, AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM INHERENT RISKS OF EQUINE ACTIVITIES.**

In exchange for the use of the property leased by MTR and other valuable consideration, I agree that my use of the premises and any animals, facilities, or equipment owned or leased by MTR is at my own risk and I further agree to indemnify and hold harmless MTR, their respective officers, employees, and agents from any and all suits, actions, or claims of any type arising from my use of the premises or participation in the equine activity of such use by my guest, whether or not such claims result directly or indirectly from the negligent act or omissions of the indemnified parties or otherwise.

I acknowledge that riding and involvement with horses is a high risk activity. I have read this agreement and fully understand its content.

**PLEASE SIGN HERE:** \_\_\_\_\_

*(Client, Parent, or Legal Guardian)*

\_\_\_\_\_  
**Date**