Equine Assisted Activities & Therapies
Registration & Emergency Treatment

CHUM Therapeutic Riding
PO Box 14
Mason, MI 48854

Phone: (517)204-0974
Email: bonnieandchum@gmail.com

Date signed **Check all that apply: New rider/volunteer** ☐ **Return rider/volunteer** ☐ **Staff** ☐ **School** ☐

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 years 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** **Email**

Phone **Cell Phone (or alternate)** **Height** **Weight**

Diagnosis **Date of Onset** **Current Age**

Previous riding experience

Parent/Guardian name **Phone**

Address **City** **State** **ZIP**

Physician 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.
Non-Consent for Treatment signature

Preferred medical facility
Is there a medical condition requiring special precautions or treatment? Yes ◯ **No** ◯
If yes, please describe:
Medication being used: Yes ◯ **No** ◯ **If yes, please list dosage and purpose:**

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 (rider's name) 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 (physician's name). 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/relationship to participant:
Name of company: **Company phone:**
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.

Signature **Parent(s)/Guardian** ◯ **Adult Participant** ◯ **Date**

Witness **Date**