



THORNCROFT THERAPEUTIC HORSEBACK RIDING, INC.
190 LINE ROAD, MALVERN, PA. 19355
(610) 644-1963 * Fax (610) 644-9342

Summer Camp Agreement and Release Form

(Complete in blue or black ink)

STUDENT Name(s): _____

ADDRESS: _____ CITY: _____ STATE: _____

ZIP: _____

STUDENT'S D.O.B.: _____ HOME PHONE: _____

WORK/CELL PHONE: _____

(If a minor):

IN CASE OF EMERGENCY, PLEASE CONTACT

Parent/Spouse/Guardian: _____

Work Phone: _____ HomePhone: _____

LIABILITY RELEASE:

In consideration of accepting the above named student in the riding program, or any other activity at Thorncroft, I understand that horses are unpredictable by nature and I voluntarily assume the risks and dangers involved. I hereby, intending to be legally bound, for myself, my heirs, executors or administrators, waive and release all claims for damages I may have against Thorncroft Therapeutic Horseback Riding, Inc., its Owners, Instructors, Volunteers, Aids, and or Employees for any and all injuries and or loses. I consent to any medical, dental, or surgical treatment or procedure of an emergency nature that is reasonably necessary to save the life of the person named above or to restore the person to health. I understand that should medical emergency treatment be required, the current insurance information listed here will be provided to the attending clinic or hospital to cover future payment of incurred bills. I have been advised that I should wear ASTM-SEI or facility approved protective head gear, hard soled shoes, and long pants in and around the stables, and while working with or riding horses, so as to help prevent horse-related injuries.

CONSENT TO TREATMENT

I authorize appropriate emergency medical care as deemed necessary by emergency medical personnel, or I authorize taking the above-named student to the emergency room of the nearest hospital. I further authorize the physician, hospital or medical personnel to provide treatment they deem necessary for the well-being of the same student.

Student is Allergic to: _____

Student takes the following

Medication: _____

Medical Insurance Co.: _____

Policy & Group #'s: _____

Family Physician: _____

Physician's Phone: _____

PHOTO RELEASE:

___The above named student hereby consents to and authorizes the use and reproduction by Thorncroft Therapeutic Horseback Riding, Inc.; of any and all photographs taken of he/she, for promotional printed material, teaching seminars, etc.

___The above named student hereby does not consent to or authorize the use and reproduction by Thorncroft Therapeutic Horseback Riding, Inc.; of any and all photographs taken of he/she promotional printed material, teaching seminars,etc.

POLICY OF CONFIDENTIALITY:

Thorncroft Therapeutic Horseback Riding, Inc. encourages the right of confidentiality for all participants in the program. All information including, but not limited to, personal, medical, and financial documents are confidential among all participants, volunteers, and staff. Confidentiality is considered one of the most basic responsibilities of our farm. I have read and understand Thorncroft's policy of confidentiality and agree to respect the same.

Parent/Guardian Signature:

Date_____