Whispers of Hope Horse Farm

Enriching the lives of mentally and physically challenged individuals through equine therapy
3549 Parkhill Road Wichita Falls, Texas 940-696-8044 www.whispersofhopehf.org

Summer Camp 2014

Challenged Rider Registration and Release Form
$30.00 per week $10.00 for T-Shirt

Registration:

Name: _____ Date of Camp Requested: _____

Street: _____ City: _____ State: _____ Zip Code: _____

(Phones) Home: _____ Parent Work: _____ Emergency: _____

Email _____(optional) Parents name_____
Fee paid $_____ check ☐ or cash ☐ for each camp.
Any donation is accepted and tax exempt receipt will be mailed to address above unless otherwise advised.
Please circle appropriate answers:
My child is ambulatory: Yes ☐ No ☐ Verbal: Yes ☐ No ☐ Special Med's: _____
wheelchair ☐ crutches ☐ braces ☐ walker ☐
Please write special request or instructions on back of this form and attach any other information necessary.

All campers should have totally enclosed shoes/boots, cool clothes, Sun Screen, towel and long pants for riding.
Please check brochure for additional information and feel free to contact the office at 696-8044.

LIABILITY RELEASE:
I _____(parent or rider over 18) would like myself or my child _____
_____ to participate in the Whispers of Hope Horse Farms Summer Camp.
I acknowledge the risks and potential risks of horseback riding. However, I feel that the possible benefits to myself/my son/my daughter/my ward 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 Whispers of Hope, its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Whispers of Hope Horse Farm programs.

WARNING - Under Texas law (Chapter 87 Civil Practice and Remedies Code), an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities.

Date: _____ Signature _____
Client, Parent, Guardian or Adult Caregiver

PHOTO RELEASE:
I hereby authorize the use and reproduction by Whispers of Hope Horse Farm of any and all photographs and any other audiovisual materials taken or me/my son/my daughter/my ward for promotional printed material, educational activities or for any other use for the benefit of the program. (No signature indicates non-consent).

Date: _____ Signature _____
Client, Parent, Guardian or Adult Caregiver

Please Complete Other Side

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Rider's Authorization for Emergency Medical Treatment

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 Whispers of Hope Horse Farm to secure and retain medical treatment and transportation if needed.

Release any record upon request to the authorized individual or agency involved in the medical emergency treatment.

Rider Name: _____ Date of Birth: _____
Parent/Guardian: _____
Home Phone Number: _____ Work Phone: _____
Cell Phone: _____ E-mail: _____
Address: _____ City: _____
State: _____ Zip Code:_____
Emergency contact: #1: _____ Phone: _____
#2: _____ Phone: _____
Physician's Name: _____
Preferred Medical Facility: _____
Health Insurance Company: _____ Policy #: _____
Rider's Disability, if applicable: _____
_____
Describe any medical condition requiring special precautions or treatment and any medications with dosage: _
_____
_____

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 below is unable to be reached.
Date: _____ Consent signature: _____
Contact Name: _____ Phone: _____

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. In the event emergency treatment/aid is required, I wish the following procedures to take place _____
_____
Date: _____ Non-Consent Signature: _____
Print Name: _____