Susan Sieber
President

Stuart Daly
Vice President

860-350-5050

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REGISTRATION AND RELEASE FORM

REGISTRATION

Student: ________________________________ Date of Birth:__________Age_____

Parent or Guardian: ____

Street: ______________________________City:________________State:________ Zip Code: ______

Home Phone:_______________ Work Phone:________________ Cell Phone:____________________

Is texting okay? ______

Email Address: ____

School or institution presently attending: ____

Please check all that apply: ___ Speech ___ OT/PT ___ Behavioral Consultant ___ Other

LIABILITY RELEASE

____________________(Students Name) would like to participate in the **Little Britches Therapeutic Riding Program**. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater that the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, and waive and release forever all claims for damages against **Little Britches Therapeutic Riding Program** it's 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 **Little Britches Therapeutic Riding Program**.

Date: _____________________ Signature: __________________________________

Student, Parent, or Guardian

PHOTO RELEASE: OPTIONAL

I hereby consent to and authorize the use and reproduction by **Little Britches Therapeutic Riding Program** of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.

Date: _____________________ Signature: __________________________________

Student, Parent, or Guardian

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize the release of information from the records of the above name participant. I also authorize the verbal exchange of information between Little Britches therapeutic riding staff and the individuals identified below. The information is to be released to **Little Britches Therapeutic Riding Program** for the purpose of developing a therapeutic riding/equine activity program for the above named participant. Please release any applicable information that is listed.

___PHYSICAL THERAPIST
Name: ______________________________
___OCCUPATIONAL THERAPIST
Name: ______________________________
___CLASSROOM TEACHER
Name:_______________________________
___BEHAVIOR ANALYST
Name: _______________________________
___OTHER
Name: _______________________________

Parent/Guardian signature: _______________________________________Date:__________

Print Name: ____