Rein-Bow Riding Academy
A service of the Therapy & Learning Center

Rider Application Form
Riding Season Year __2025___

Participant: _____

Date of Birth: _____ Age: _____ Gender: M F Height: _____ Weight: _____

Address: _____City: _____ State: _____ Zip: _____

Parent/Guardian(s): _____

Home phone: _____ Cell phone(s): _____

Work phone: _____ E-mail: _____

In case of emergency: Contact: _____ Phone: _____

Contact: _____ Phone: _____

Physician(s): _____

Diagnosis: _____

School attending: _____ Grade: _____

How did you find out about the program? _____

Does your child receive any therapy services? If so, please describe: _____

Goals (i.e., what would you like to gain from this experience?): _____

_____

Please check the session dates in order in which you would prefer (1st, 2nd, & 3rd). With the number of riders, times and dates selected are not guaranteed.

March 4th – May 6th: _____ May 13th – July 15th: _____ Aug 26th – Oct 28th: _____

Please check order preference (1st, 2nd, etc.) all session times when your child is available to participate in lessons:

____ 4:15 – 5:00 pm ____ 5:00 – 5:45 pm ____ 5:45 – 6:30 pm ____ 6:30 – 7:15 pm ____7:15 – 8:00 pm

Signature: _____ Date: _____

Note: Should the physical condition of the participant change at any time, a new physician's referral form must be completed. Any surgeries or change in medication must be reported immediately. Contact your instructor for additional forms.

For office use only: Full packet received by: _____ Date received: _____

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Therapeutic Horseback Riding
Waiver and Release of Liability

The Therapy & Learning Center is offering the Therapeutic Horseback Riding Program to help participants advance their therapeutic goals and over all sense of well-being. Before beginning any physical program, you should consult with your physician. Horseback riding is a physical activity is which, despite careful and proper preparation, instruction, and medical advice, there can still be a substantial risk of injury. Please read this form carefully and be aware that by participating in the Therapeutic Horseback Riding Program you will be waiving your rights to all claims for any injuries you might sustain, and you will be required to indemnify, hold harmless, and defend Jackson-Madison County General Hospital District operating as West Tennessee Healthcare ("WTH"), including any of its subsidiaries, for any claims arising out of your participation in this program.

_____

Acknowledgement of Status and Responsibility: I acknowledge and agree that I am voluntarily participating in the Therapeutic Horseback Riding Program and that I am responsible for my own safety, health and welfare.

Risk of Injury: I recognize and acknowledge that physical activity carries the risk of injury, and I agree to assume the full risk of injuries, including death, disability or personal injury, property damage, property theft, or actions of any kind which may hereafter occur to me including my traveling to and from the Therapeutic Horseback Riding Program, or loss which I may sustain as a result of my participation. I understand that my participation is voluntary, and that I am choosing to accept the risks involved.

Waiver and Release of Liability: In consideration of my participation, I agree on behalf of myself, my heirs and assigns, to waive, release and forever discharge WTH and any of its affiliates from any and all claims of negligence or other actions, whether foreseeable or unforeseeable, which may at any time, arise out of or relate to my participation. This waiver and release of liability includes any injury which may occur while on the premises.

Indemnity: I agree to indemnify, hold harmless and defend WTH, its officers, agents, and employees from any and all claims related to injures sustained by me and arising out of, connected with, or in any way associated with the activities or participation in the Therapeutic Horseback Riding Program.

Agreement Not to Sue: I agree on behalf of myself, my heirs and assigns not to sue WTH for any reason related to my participation.

Emergency Treatment: In the event of any emergency, I authorize WTH to secure any treatment deemed reasonable and necessary, and agree that I will be responsible for payment of any and all medical services rendered.

2025

I have been given ample time to read this Acknowledgement and Release, and I have read and fully understand its contents. I understand that it is a release of liability and an acknowledgement of responsibility, and I sign this document knowing that I am waiving any right to bring a legal action against WTH for any claim relating to my participation in the Therapeutic Horseback Riding Program.

For Participants and Volunteers Over 18 years of Age:

Print Participant's Name: _____

Participant's Signature: _____

Date: _____

Cell Phone: _____

For Participants Under 18 years of age –or- Adult participants under the care of a guardian:

I am the parent or guardian of _____ and hereby certify that he or she has my permission to participate in this Therapeutic Horseback Riding Program. I have read this release and intentionally and voluntarily accept its terms.

Guardian's Print Name: _____

Guardian's Signature: _____

Date: _____

Guardian's Cell Phone: _____

Rein-Bow Riding Academy/Therapy & Learning Center
Authorization for Emergency Medical Treatment Form Year 2025

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current medications: _____

In the event of emergency contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Consent Plan
In the event that 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 Rein-Bow Riding Academy to:

1. Administer emergency treatment.
2. Secure and retain medical treatment and transportation, if needed.
3. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

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 will the following to take place:

_____
_____
_____

Date:_____ Non-Consent Signature:_____
Client, Parent or Legal Guardian

Rein-Bow Riding Academy/Therapy & Learning Center

Consent to Photograph Year 2025

I, _____, hereby grant and assign to Jackson-Madison County General Hospital District and/or West Tennessee Healthcare ("WTH") a non-exclusive, royalty-free license to use any and all photographs, videotapes, digital images, and audio recordings taken of me and/or child by or for representatives of the system. I understand and agree that this material may be used in one or all of the following:

Radio / Television Broadcasts

Newspaper / Magazine Articles

Print Materials / Advertisements

Web Site / Internet

This consent will not expire until such time as the District and/or WTH no longer desires to use or disclose the information described above for the general purposes for which this consent was obtained. You may revoke this consent, and if you wish to do so, you may send a letter to the Privacy Coordinator, West Tennessee Healthcare, 620 Skyline Drive, Jackson, TN 38301.

Signature: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Witness: _____

REIN-BOW RIDING ACADEMY/THERAPY & LEARNING CENTER
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
(MARKETING/PUBLIC RELATIONS)

NAME:	**Date of Birth:**	**SS No. (optional)**
ADDRESS:	**RELEASE PROTECTED HEALTH INFORMATION TO:**	
TELEPHONE:	**JACKSON-MADISON COUNTY GENERAL HOSPITAL DISTRICT; THERAPY & LEARNING CENTER**	

INFORMATION BEING RELEASED BY:

Purpose of Disclosure:
☐ At the Request of the Individual Identified Above
☒ Media, Public Relations, Marketing, Advertising, Posting, or Radio or Television Broadcasting
☒ Other, Please Explain: Fundraising Activities

Description of Information to be Used or Disclosed: __X_ Photographs/Video of me and/or my child
____ Other (specify):

I understand that:

1. I may revoke this authorization in writing at any time, but if I do so, it will not have any effect on any actions taken by the facility releasing the information (hereafter referred to as "the facility") prior to the facility's receiving the revocation. Further details regarding the manner in which this authorization may be revoked may be found in the facility's Notice of Privacy Practices.
2. This authorization allows the facility to release the above requested documents. The released information may no longer be protected by federal privacy regulations and may be redisclosed.
3. The facility is hereby released from any liability and the undersigned will hold the facility harmless for complying with this authorization.
4. The facility will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization, except for research related purposes and as otherwise permitted under applicable law.
5. The authorization will not expire until such time as the facility no longer desires to use or disclose the information described above for the general purposes for which this authorization was obtained.
6. If the facility will use or disclose my protected health information for marketing purposes, the facility will not receive remuneration or compensation for such use or disclosure for marketing purposes unless the WTH Privacy Coordinator completes and signs the following statement:

I, _____ (signature of WTH Privacy Coordinator) hereby certify that the facility will receive remuneration or compensation for the use or disclosure of this patient's protected health information from _____ (fill in source of remuneration or compensation).

I have read and understood this authorization. I hereby authorize the use and disclosure of the above-requested protected health information.

_____ _____

Signature **Signature of Authorized Representative**

_____ _____

Date **Description of Representative's Authority to Act for Individual**