

Reins in Motion Foundation Informed Consent Release of Liability

Name (participant)

Address

City, State, Zip

Age at date of session

Name of guardian (if participant is a minor) _____

If the above-listed Participant is under 18 years of age, I hereby declare that I am authorized as their guardian to sign this Legal Release on their behalf, and understand and agree that they are bound by all terms and conditions of this document.

In consideration of the services provided by Reins in Motion Foundation (RIM) & their respective agents, employees, directors, officers, contractors, volunteers, in connection with Participant's participation at Reins in Motion, I as Participant or, if Participant is a minor, as parent/guardian of Participant agree as follows:

I am familiar with the Program and all of my questions about the Program, including questions concerning the details of activities, the physical conditions, and the Program's location have been answered to my satisfaction. I understand that participation in the Program creates a risk of injury and I expressly acknowledge and assume the risk of such injury to the Participant. The following describes some of those risks.

- The Program involves outdoor activities where exposure to environmental risks include poison oak, insects, snakes, predators, unpredictable forces of nature such as storms, earthquakes, and wildfires. Entering restricted areas on the property is prohibited and could be dangerous.
- The Program may require travel to an off-site activity by bus or vehicle and includes: horseback riding. Possible injuries include sunburn, dehydration, heat stroke, slipping, falling, drowning, and other mild or serious injuries and conditions.
- An environment free of allergens, including but not limited to food allergens, cannot be guaranteed at Reins in Motion. Therefore, RIM cannot guarantee the Participant will not come into contact with any allergens while at Reins in Motion. Participation in the program will expose the participant to food, activities and persons that may result in exposure to allergens and injury.

I agree that this description of risks is not complete, and that unknown or unanticipated risks may result in property loss, injury, or death. I understand that the unique character of this Program is to serve participants who are medically fragile or high risk. I have submitted, to the best of my knowledge, complete health history information to the ENN and represent that Participant is free from medical or physical conditions that might create undue risk to Participant. I represent that Participant is fully capable of participating in this Program. Therefore, I assume and accept full responsibility for any injury, death, loss of personal property, and/or expenses that may result from Participant's involvement in this Program, and I further agree to indemnify and hold harmless Exceptional Needs Network and their agents, employees, directors, officers, contractors, volunteers, and all entities associated with it to the fullest extent of the law, from any and all damages, losses or liability that may result from Participant's involvement in the Program.

Participant Signature (if age 18 or older) _____ **Date:** _____

Parent/Guardian Signature _____ **Date:** _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Print Participant Name _____ Date of Birth _____

Print Parent/Guardian Name (if applicable) _____

Address _____

City _____ State _____ Zip _____

Hm.Ph. _____ Wk.Ph _____ Cell _____

In the Event I cannot be reached:

Contact _____ Phone _____

Alternate Contact _____ Phone _____

Physician's Name _____ Phone _____

Preferred Medical Facility _____ Phone _____

Health Ins.Co. _____

List all pertinent medical information (allergies to food or drugs, medications being taken, special medical condition _____

CONSENT PLAN

In the event of an emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or working in program or while being on the property of the agency, I authorize Reins in Motion Foundation to:

- 1.) Secure and retain medical treatment and transportation if needed.
- 2.) Release client records upon request to the authorized individual or agency

Date _____ CONSENT SIGNATURE _____

Print Name and Relationship _____

NONCONSENT PLAN

I do not give my consent for emergency medical treatment in the case of illness or injury during the process of receiving services, working in program or while being on the property of RIMF In the event of emergency treatment/aid is required I wish the following procedures to take place:

Date: _____ NONCONSENT SIGNATURE _____

Name and Relationship: _____

