Charleston Area Therapeutic Riding, Inc.
P.O. Box 146 • Johns Island, SC 29457-0146 • (843) 559-6040 • Fax (843) 559-0176

P1 RIDER'S REGISTRATION AND RELEASE FORM

Student:_______________________________________ Date of Birth: ____________________

Address: _____________________________________Dates lived there:_________________

City: __________________________________State: ________ Zip Code: ________________

____ __________________________
Other Names Used (including maiden name) YEARS USED

_______-_______-_________ ____

SOCIAL SECURITY NUMBER DRIVER'S LICENSE # STATE ISSUED

Home Phone: ________________ Work Phone: _______________ Cell: ________________

Email: ____

Name of School, Institution or Employment: _______________________________________

In case of Emergency: Contact:____________________________ Phone: _______________

LIABILITY RELEASE

___________________________ (client's name) would like to participate in the Charleston Area Therapeutic Riding, Inc. program. I acknowledge the risks and potential for risks of horsemanship and horseback riding. However, I feel the possible benefits to myself / my son / my daughter / my ward are greater than the risks 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 Charleston Area Therapeutic Riding, Inc.

_________________________ ____
Date Signature of Student

If Student cannot legally sign for him or her self, then Legal Guardian must sign below.

________________________ ____
Date Legal Guardian of Adult Student

PLEASE SIGN ONLY ONE CONSENT BELOW

PHOTO RELEASE

I hereby consent to and authorize the use and reproduction by Charleston Area Therapeutic Riding, Inc. of any and all photographs and any other audiovisual materials take of me / my son / my daughter / my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

_______________________ ____

Date Signature of Student

If Student cannot legally sign for him or her self, then Legal Guardian must sign below.

_______________________ ____

Date Legal Guardian of Adult Student

NON-CONSENT

I do not consent to the use of photographs etc. as defined above.

_______________________ ____

Date Signature of Student

If Student cannot legally sign for him or her self, then Legal Guardian must sign below.

_______________________ ____

Date Legal Guardian of Adult Student

CRIMINAL DISCLOSURE

1. Have you ever been convicted of or pleaded guilty to a felony? Yes [ ] No [ ]
2. Have you ever been convicted of or pleaded guilty to a misdemeanor? Yes [ ] No [ ]
3. Are you awaiting trial for any crime or violation other than a minor traffic infraction? Yes [ ] No [ ]

If "Yes" to either question, please describe the conviction(s) in detail, including dates:

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CONSENT & PROCESS for CRIMINAL BACKGROUND CHECK

Each CATR adult student who is to receive a criminal background history check must sign an authorization / waiver / indemnity form (below), giving approval for CATR and their assigned agents to access the results of a criminal background search. Once you have signed this agreement, a Certified Background Inc. will be used to perform the check, CATR and their assigned agents can see the results of the check, which will show record of criminal history. A background check is required for all CATR students who are age 18 and older.

Certification & Authorization

I certify that the information I have provided is true and complete to the best of my knowledge. I understand that misrepresentation, falsification, or omission of information may disqualify me from further consideration as a student, or may result in my dismissal.

If accepted as a student, I understand that I must abide by all CATR policies, rules and regulations.

I authorize CATR to investigate all statements contained in this application and to make inquiries of my medical history, as well as other matters as may be necessary for determining my eligibility as a student. I hereby release physicians, employers, schools or individuals from all liability in responding to inquiries relating to my student application.

______________________________________ ____________

Signature of Student or Guardian Date

If Student cannot legally sign for him or her self, then Legal Guardian must sign below.

______________________ ____

Date Legal Guardian of Adult Student

Thank You!