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: _____

City: _____State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email: _____

Name of School, Institution or Employment: _____

Name of Parent or Guardian: _____

Address, City, State: _____ Phone: _____

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 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 Client, Parent or Guardian

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 Client, Parent or Guardian

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

_____ _____
Date Signature of Client, Parent or Guardian