

Three Gaits, Inc.

Therapeutic Horsemanship Center

MAILING ADDRESS:
P.O. Box 153
Oregon, WI 53575
(608) 877-9086 (Office)
www.3gaits.org

PHYSICAL ADDRESS:
3741 Hwy. 138 W
Stoughton, WI 53589
(608) 873-1929 (Barn)
3gaits@3gaits.org



Client Release Form

Client: _____ Home Phone: _____
Street: _____ City: _____ Zip: _____
Primary Email: _____ Height: _____ Weight: _____
Date of Birth: _____ Age: _____ School presently attending: _____
Parents/Guardian(s): _____
Address/Phone: _____
Parent/Guardian contact phones/emails: _____

Liability Release (REQUIRED)

In return for being allowed to use the Three Gaits, Inc. Therapeutic Horsemanship Program, including its facilities, horses and equipment, where applicable for horseback riding and other horse related activities, I/my son/my daughter/ my ward _____ (Client's Name) agree to abide by all the rules and regulations of Three Gaits, Inc. now in effect or later adopted. In addition, I hereby agree to assume all responsibility and risk from my/my son/my daughter/my ward's participation in activities of Three Gaits, Inc. I further agree to hold Three Gaits, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees free and harmless from all damages or liability for any injury to person or property arising as a result of the use of facilities, horses and or equipment owned or leased to Three Gaits, Inc., including any injury caused by their negligence.

I am aware of the significant risks of injury that horseback riding and horse-related activities may cause to myself/my son/my daughter/my ward, however I feel that the possible benefits to myself/my son/my daughter/my ward are greater than and out weigh the risk assumed. By signing this agreement I am assuming all risk and do hereby understand that horses are animals, not subject to any guarantee of reliability. Therefore, I agree to release, indemnify and hold harmless Three Gaits, Inc., the Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees from all liability they may incur.

In accordance with the Wisconsin Law relating to the limitation of civil liability regarding equine activities: "NOTICE: A person who is engaged for compensation in the rental of equines or equine equipment or tack or in the instruction of a person in the riding or driving of an equine or in being a passenger upon an equine is not liable for the injury or death of a person involved in the equine activities resulting from the inherent risks of equine activities, as defined in section 895.481 (1) (e) of the Wisconsin Statutes."

Date: _____ Signature: _____
Client, Parent or Guardian

Photo Release (REQUIRED)

I do I do not consent to and authorize the use and reproduction by Three Gaits, Inc. of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Exceptions: _____

Date: _____ Signature: _____
Client, Parent or Guardian

Authorization for Emergency Medical Treatment (REQUIRED)

Consent Plan

In the event 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 Three Gaits, Inc. to:

- 1. Secure and retain medical treatment and transportation if needed.
- 2. 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 below is unable to be reached.

In the event I _____ cannot be reached, please call;
Client, Parent or Guardian

Contact/Relationship: _____ Phone: _____

Contact/Relationship: _____ Phone: _____

Physician's Name: _____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Policy #: _____

Date: _____ Consent Signature: _____
Client, Parent or Guardian

Print Name: _____ Phone: _____

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. In the event emergency treatment/aid is required, I wish the following procedures to take place: _____

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

Print Name: _____ Phone: _____