

**-LASATA-**

8 Abbott Lane Coatesville, PA 19320 610-886-4888

**EMERGENCY TREATMENT RELEASE**

Participant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian (if under 18): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone (please specify home, work, cell): \_\_\_\_\_

Secondary Phone (please specify home, work, cell): \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Health Insurance Provider: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Allergies: \_\_\_\_\_

Describe any medical condition(s) requiring precautions/treatment and any medications with dosage(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_ I GIVE MY CONSENT: In case of a medical emergency, the undersigned authorizes Lasata to provide such medical assistance as they determine necessary. The undersigned authorizes any licensed physician and/or medical facility to provide medical surgical care and/or hospitalization for the participant, including anesthetic, which they determine to be necessary or advisable, pending receipt of a specific consent from the undersigned.

**OR**

\_\_\_\_ 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: \_\_\_\_\_

\_\_\_\_\_

No participant can be accepted for horse assisted learning or therapy until this form has been completed and signed. If the participant is of legal age (18), he/she may complete the form if he/she is legally competent to do so. Riding instruction and horse assisted therapies and learning opportunities, will be under strict supervision, and although every effort will be made to avoid any accident, **NO LIABILITY** can be accepted by any of the organizations, employees, owners, director or volunteers concerned. In the event of an 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 Lasata Farm LLC/Lasata 501c3 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.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

*(Participant if Legally Able or Parent/Guardian)*

PRINT NAME: \_\_\_\_\_ RELATIONSHIP TO PARTICIPANT: \_\_\_\_\_

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LIABILITY RELEASE

I agree to the following agreement with Lasata, Pennsylvania based non-profit organization (hereafter referred to as "Center") as a condition for allowing me, and the persons identified below, to enter the Center's premises and surrounding land, be near horses and other farm animals, participate in equine-assisted activities, work near horses and other farm animals, handle horses and other farm animals, use equipment, work with the owners, director, other staff and volunteers, and/or receive instruction or guidance in riding, grooming, or handling of horses and other farm animals (these activities will hereafter be referred to in this document as "The Activities").

Participants Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Lasata Farm: \_\_\_ Participant/Student \_\_\_ Volunteer \_\_\_ Staff \_\_\_ Event Participant \_\_\_ Boarder/Lessee

Parent/Guardian Name(s) or Spouse's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**IT IS HEREBY AGREED AS FOLLOWS:**

1. I have requested to engage in any or all of The Activities, now and/or in the future.
2. **Risks.** I understand that anyone engaging in The Activities can suffer bodily and other injuries. Participation in The Activities involved certain inherent risks and, regardless of the care that is taken, it is impossible to ensure the safety of the participant. **I understand the risks/dangers inherent in The Activities, and I agree to assume them. I am not relying on the Center to list all possible risks for me.** I have discussed the potential risks The Activities pose to family members including those who may visit the Center.
3. **Waiver and Liability Release.** As consideration for The Center allowing me to engage in The Activities at any time and at any location, I agree to assume full responsibility for any and all bodily injuries, losses, or damages that I, my family, assistants, aids, friends, therapists, or anyone that accompanies me may sustain. I, for my heirs, administrators, personal representatives, or assigns, release and discharge the Center and Lasata Farm LLC, their employees, therapists, aids, assistants, board members, directors, volunteers, land owners, and owners of horses from any and all claims, demands, damages, actions, omissions, losses, suits, or causes of action (present or future).
4. **Indemnification.** I also agree to indemnify and hold harmless the Center and Lasata Farm LLC, and persons or entities working on behalf of or affiliated with the Center against all damages, which are sustained or suffered by any third persons. The indemnification shall include reimbursement of Center's attorney fees. Should I breach this Release (or any part of it) I agree to pay the attorney's fees and court costs related to such breach incurred by Center and/or persons directly affiliated with Center. It is also mutually agreed that any disputes arising under this Release, or any activities that are undertaken pursuant to this document, shall be litigated in a court of proper jurisdiction.
5. **ASTM/SEI Headgear.** Lasata can provide me with an equestrian safety helmet that is ASTM-standard or SEI-certified for use when riding, handling, or near horses; mandatory to be worn while participant is mounted. I understand that neither the Center nor its assistants or agents can guarantee the suitability of any helmet provided. You are welcome to purchase your own ASTM/SEI Equestrian approved helmet.
6. **Health and Disabilities.** I understand that The Center always recommends that I seek the advice of a physician, and many of The Activities pose special physical risks to the participant and even to the volunteer. I want The Center to be aware of the following physical conditions I have that may affect my ability to handle, ride, and/or be near an equine or other farm animal:

8. **Photo Release.** The above named participant hereby \_\_\_ **Authorizes** \_\_\_ **Does Not Authorize** the use and reproduction by Lasata of any and all photographs, other audiovisual materials taken of myself/my family/my ward for promotional and or printed materials, educational activities, exhibitions, social media or for any other use for the benefit of the program.

9. **Policy of Confidentiality.** All information including but not limited to, personal, medical, and financial documents is confidential.

Signature of Contracting Party: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Contracting Party: \_\_\_\_\_

*(Participant if Legally Able or Parent/Guardian)*

Signature of Other Contracting Party: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Other Contracting Party: \_\_\_\_\_