Greystone Manor Therapeutic Riding Center

**Participant's Name** _____ **Date** _____

## PARTICIPANT REGISTRATION; PHOTO RELEASE; AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

| **REGISTRATION – PLEASE PRINT** | | ***(Remember to make a copy of this form for your records.)*** | |
|---|---|---|---|
| **DOB (MM/DD/YY)** | **Age:** | **(Check one) ☐ Male ☐ Female** | **Race** *(optional)*: |
| **New Participant: ☐ Yes ☐ No** | | **How did you learn about GMTRC?** | |
| **Participant Address:** | | | **City, State, Zip** |
| **Participant Employer or School:** | | | |
| **Parents' or Guardians' Full Names:** | | | |
| **Parents' or Guardians' Address (if different from above):** | | | **City, State, Zip** |
| **Email address(es):** | | | |
| **Phone – Home:** | **Cell:** **Text? ☐ Yes ☐ No** | | **Emergency:** |
| **Parent /Guardian place of employment: (Father)** | | | **(Mother)** |

| | | | |
|---|---|---|---|
| **Caregiver Name:** | | **Group Home Name:** | |
| **Caregiver Phone:** | **(w)** | **(c)** | **(fax)** |
| **In event parent/guardian or caregiver cannot be reached:** | **Contact:** | **Relationship:** | **Phone:** |

| **PHOTO RELEASE: (Check one) ☐ I DO CONSENT ☐ I DO NOT CONSENT** | |
|---|---|
| **I hereby (consent to or not consent to) the use and reproduction by Greystone Manor TRC of any and all photographs and any other audio-visual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, exhibitions, including website, Facebook or for any other use for the benefit of the program.** | |
| **Date:** | **Signature of Participant/Parent/Guardian:** |

| **AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT – signature required on either Consent Plan or Non-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 Greystone Manor TRC to: 1) secure and retain medical treatment and transportation if needed; and 2) release participant records upon request to the authorized individual or agency involved in the medical emergency treatment.** | |
| **Print Physician's Name:** | **Phone:** |
| **Preferred Medical Facility:** | **Health Insurance Company:** |
| | **Policy No.:** |
| **Date:** | **Signature of Participant/Parent/Guardian:** |

| **CONSENT PLAN ☐ I DO CONSENT** | | |
|---|---|---|
| **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 listed below is unable to be reached.** | | |
| **Date:** | **Signature of Participant/Parent/Guardian:** | |
| **Printed Name:** | **Phone:** | **Address:** |

| **NON-CONSENT PLAN ☐ I DO NOT CONSENT** | |
|---|---|
| **I DO NOT give consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while on the property of the agency. In the event emergency treatment/aid is required, I WISH THE FOLLOWING PROCEDURES TO TAKE PLACE:** | |
| | |
| **Date:** | **Signature of Participant/Parent/Guardian:** |