BEATS
www.BEATS-Inc.org

Mailing address: 1704 Winston Court Woodstock GA 30189
Facility address: 75 Red Gate Trail Canton Ga 30115
Email: bethany@beats-inc.org
Phone: 404-644-3917 Fax: 678-494-6616

DATE (mm/dd/yyyy)	

PARTICIPANT INFORMATION

Name		**DOB** (mm/dd/yyyy)		**Age**	
Parent/Guardian Names (if under 18)					
Street Address					
City		**State**		**Zip Code**	
Home Phone		**Cell Phone**		**Work Phone**	
Email Address					

It is the mission of BEATS, Inc to provide hippotherapy and therapeutic riding services to individuals with special needs. However, to help support our program, BEATS, Inc provides lessons to typical riders as well.

- ☐ This rider has physical, cognitive or emotional/behavioral needs (Please fill out additional papers)
- ☐ This rider has no special needs
- ☐ Participant is a volunteer

EMERGENCY CONTACTS

Name		**Relationship**		**Phone**	
Name		**Relationship**		**Phone**	

LIABILITY RELEASE

Be it known that under Georgia Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities pursuant to Chapter 12 of Title 4 of the Official Code of Georgia Annotated.

_____(Client's Name) would like to participate in the Bethany's Equine and Aquatic Therapy Services, Inc (BEATS, Inc) program. I acknowledge the risks and potential for risks of horseback riding programs. However, I feel that the possible benefits to me/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, indemnify, hold harmless, waive and release forever all claims for damages against BEATS, Inc., its Board of Directors, Instructors,. Therapists, Aides, Volunteers and/or Employees, as well as the owners of the property, Mariposa Farms, LLC, their officers and family members, agents, employees, and contractors for any and all injuries and/or losses, including theft, loss of property, or death that I may sustain while participating in the BEATS, Inc program.

Client or Parent/Guardian Signature		**Date**	

PHOTO RELEASE

I hereby consent to and authorize the use and reproduction of any and all photographs and other audiovisual materials taken of me, my son, daughter or ward for promotional printed material and/or educational activities for BEATS, Inc. program.

I consent	☐	**I DO NOT consent**	☐		
Client or Parent/Guardian Signature				**Date**	

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Name		**Physician's Name**	
Preferred Medical Facility			
Health Insurance Company		**Policy Number**	

Current Medications	**Allergies**

CONSENT PLAN

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.

Participant or Parent/Guardian Signature		**Date**	
**If Parent or Guardian*			
Name		**Phone**	
Address			

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 is required, I wish the following procedures to take place:

Participant or Parent/Guardian Signature		**Date**	
**If Parent or Guardian*			
Name		**Phone**	
Address			