Banbury Cross
Therapeutic Equestrian Center

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International
CENTER MEMBER

2025 Participant's Liability and Authorization for Medical Treatment Form

Participant Name: _____
Physician's Name: _____Preferred Medical Facility: _____
Health Insurance Company: _____ Policy #: _____
Allergies to medications: _____
Current Medications: _____

In the event of an emergency, contact:
Name: _____Relation: _____Phone: _____
Name: _____Relation: _____Phone: _____

Liability Release

_____ (Participant's Name) would like to participate in the Banbury Cross Therapeutic Equestrian Center Program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk 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 Banbury Cross Therapeutic Equestrian Center, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Banbury Cross Therapeutic Equestrian Center's program.

Under the Michigan Equine Activity Liability Act, an equine professional is not liable for any injury to or the death of a participant in an equine activity resulting from an inherent risk of the equine activity.

Date: _____ Signature: _____
Participant (*if participant is over 18 and legally responsible),* Parent or Legal Guardian

PLEASE CHOOSE:

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(s) above is unable to be reached.

Date: _____ Consent Signature: _____
Participant (*if participant is over 18 and legally responsible),* Parent or Legal Guardian

-or-

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: _____
Participant (*if participant is over 18 and legally responsible),* Parent or Legal Guardian