General Liability Release

The undersigned is aware that all activities involving horses including but not limited to riding, driving, grooming, leading or events involving horses pose many inherent dangers, risks and hazards including but not limited to bodily injury and physical harm to rider, groomer, leader, handler, side walker, photographer, spectator and/or helper. I (the undersigned) freely assume all such risks, dangers, and hazards. I hereby agree as follows

(Initial each number to indicate that you have read, understand and agree):

_____1) To assume and accept all risks, dangers and hazards in connection with my use or my minor child's or ward's use of the facilities and activities at Chakota Therapeutic Riding Center, hereinafter ("Chakota") or any off site activities sponsored by Chakota.

_____2) To waive any and all claims that I may have against Chakota and the property owners as a result of my, my minor child or ward's use of the facility or participation in any off site activity sponsored by Chakota.

_____3) To release Chakota, its employees, board of directors, agents, volunteers, spectators, participants, guests, property owners and all people involved with Chakota from any and all liability, rights of action, or causes of action arising out of contract, tort or otherwise for any loss, damage, injury or expense that I, my minor child or ward, or next of kin of myself may suffer or incur as a result of use of the facilities and activities or participation in offsite activities sponsored by Chakota due to any cause whatsoever.

_____4) The undersigned agrees to hold harmless Chakota, and any employees, volunteers, board of directors, agents, spectators, participants and or property owners form any and all liability for personal injury, property damage or death suffered by myself, my minor child or ward or by a third party as a result of use and/or presence at the facility or activities or off site activities sponsored by Chakota.

_____5) That, in the event of my, my minor child or ward's injury or death, this release and indemnity agreement shall be effective and binding upon mine and my minor child or ward's heirs, next of kin, executors, administrators and assigns in relation to Chakota, it's property owners and any and all people involved.

Adult:

I acknowledge that I have read and understood this release. I am at least 18 years of age and am aware that by signing this document, I am releasing legal rights for myself, my heirs, next of kin, executors, administrators, and assigns or in relation to Chakota, its property owners and any and all people involved.

Date:_____Name:_____(print legibly)

Signature:_____

Witness:_____

Minor or ward:

I acknowledge that I have read and understood this release and indemnity. I am 18 years of age or older. I have the authority as the parent or legal guardian or legal representative of _____ (Please print legibly) to sign and release on behalf of the minor/ward so that the minor/ward may participate and use the facilities and activities offered by Chakota. I am waiving legal rights and liabilities of the minor/ward, his/her heirs, next of kin, executors, administrators, and assigns in relation to Chakota, its property owners and any and all people involved.

Date:_____Name:_____(print legibly)

Signature:_____

Witness:_____

Photo Release

In consideration for being accepted into the Chakota Therapeutic Riding Center volunteer program and for the valuable personal benefits I receive from participating in the program and promoting the program, I, (please print)_____, hereby AUTHORIZE Chakota Therapeutic Riding Center, its advertising agencies or the news media to have photographs, films or other audio-visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the Chakota Therapeutic Riding Center program. I hereby indemnify and hold Chakota Therapeutic Riding Center harmless against any and all claims of damages arising out of the use of any such photographs or films of me or audio-visual materials containing my image.

Applicant's Signature: _____ Date: _____

Legal Guardian's Signature:_____Date: _____
(The Legal Guardian of the Applicant must sign if the Applicant is less than 18 yrs old.)

~~~OR~~~

I, (please print)_____, hereby DO NOT AUTHORIZE Chakota Therapeutic Riding Center, its advertising agencies or the news media to have photographs, films or other audio-visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the Chakota Therapeutic Riding Center program.

Applicant's Signature: _____ Date: _____

Legal Guardian's Signature:_____Date: _____
(The Legal Guardian of the Applicant must sign if the Applicant is less than 18 yrs old.)

WARNING

Under Illinois law, an 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 the Revised Statutes of Illinois.
~~~

Volunteer Pledge and Commitment

I understand as a volunteer I am agreeing to help and support Chakota Therapeutic Riding Center and their needs, whatever they may be.

I understand that a student's right to privacy and a parent's right to privacy must be respected. Therefore I understand I am to hold such information in confidence and not to divulge the information to any person.

I have filled out the background check form and understand that I may be asked to refrain from volunteering at Chakota Therapeutic Riding Center if the check comes back with any questionable information.

I will honor my schedule and commitment. I will try to be an appropriate model for my participants in my dress, language, and behavior. I will abide by the smoking policy and refrain from discussing my concerns with those who are not directly involved with the situation. I understand I am to bring my concerns to the Volunteer Coordinator or Program Director.

Date:_____

Signature:_____

Phone Number: ( ) _____

Authorization for Emergency Medical Treatment Form

(circle one) Participant Staff Volunteer

Name:_____ DOB:_____
Phone: _____

Address:_____

Physician's Name:_____
Medical Facility:_____

Health Insurance Company:_____
Policy#:_____

Allergies to medications:_____

Current medications:_____

Epi-pen (circle) Yes No Inhaler (circle) Yes No

In the event of an emergency, contact:

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

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 Chakota Therapeutic Riding Center (Operating Center's Name)
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.

Do you have any medical conditions you wish us to be aware of for safety reasons? (Please note this form is accessible to Chakota staff and volunteers.)

_____

_____

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, Parent or Legal Guardian

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:_____ Consent Signature:_____
Participant, Parent or Legal Guardian

CFS 689
6/2001

State of Illinois
Department of Children and Family Services

AUTHORIZATION FOR BACKGROUND CHECK

Child Abuse and Neglect Tracking System (CANTS)

For Programs NOT Licensed by DCFS

NOTE: Do not use this form if you are an applicant for licensure or an employee/volunteer of a licensed child care facility. Please contact your licensing representative.

Name: _____
Last First Middle

Date of Birth: _____ Gender (circle): Male Female Race: _____

Current Address: _____
Street/Apt #

_____
City State Zip Code

List all addresses at which you have resided in the past five years:

_____

_____

_____

_____

_____

List maiden name and/or all other names by which you have been known: (last, first, middle)

_____ _____

_____ _____

_____ _____

_____ _____

I hereby authorize the Illinois Department of Children and Family Services to conduct a search of the Child Abuse and Neglect Tracking system (CANTS) to determine whether I have been a perpetrator of an indicated incident of child abuse and/or neglect or involved in a pending investigation. I further consent to the release of this information to the agency listed below.

_____
Signed Date

Please type, use bold letters or label:

Mail this request to:
Department of Children and Family Services
406 E. Monroe – Station # 30
Springfield, IL 62701

Chakota Therapeutic Riding Center (Agency Name)

Kay Langenhorst 618-334-0885 KayL@chakota-trc.org (Contact Person)

6248 Wesclin Rd (Address)

Germantown, IL, 62245 (City/State/Zip)

N/A (Submitting Agency Fax Number)