Health History: *Please complete the below chart. If "yes" to any category please explain and/or provide medical diagnosis*.*

	Yes	No	Comment
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional./Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognitve			
Allergies			

*A medical diagnosis may require an additional form be completed before riding or equine activities begin.

Medications: _____

_____

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to or infected by COVID-19 by attending activities at ***Shady Hollow Assisted Riding (SHAR)*** and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at SHAR may result from the actions, omissions, or negligence of myself and others, including, but not limited to, SHAR employees, volunteers, and program participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my child(ren)'s attendance at ***Shady Hollow Assisted Riding*** or participation in ***SHAR*** programming. On my behalf, and on behalf of my children, I hereby release, covenant not to sue, discharge, and hold harmless ***Shady Hollow Assisted Riding***, its employees, agents and representatives, of and from ***SHAR***, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of ***Shady Hollow Assisted Riding***, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any ***SHAR*** program.

Date: _____ Signature: _____

Date: _____ Parent/Guardian Signature: _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury during the process of volunteering, or while being on the property, I authorize **SHADY HOLLOW ASSISTED RIDING** to:

1. Secure and retain medical treatment and transportation if needed.
2. Release information and records upon request to the authorized individual or agency involved in the medical emergency treatment.

Emergency Contact Information:

Name: _____ Phone: _____

Relationship: _____

Physician Contact Information:

Name: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Policy #: _____

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 listed below is unable to be reached.

Date: _____ Consent Signature: _____

Print Name: _____

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 volunteering or while being on the property. In the event emergency treatment/aid is required, I wish the following procedures to take place:_____

_____

Date: _____ Consent Signature: _____

Print Name: _____

SHAR is a 501(c)3, nonprofit organization. Financial support from individuals and companies are crucial to maintaining the health and wellness of our horses, property and equine programs. If you work for a company that makes annual donations, please take a moment to complete information below.

Contact Name: _____

Name of Company:_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____