



## RIDER RELEASE FORM

Please read this form carefully. It contains important liability releases and emergency medical authorization. Validate by signing in appropriate areas. It is only necessary to sign once at the end of the form if you agree to all terms. Non-consent areas are provided for specific exceptions. Chuckie's Place d/b/a Reigning Hope Therapy Services of Colorado, herein referred to as RHTS requires this form to be updated annually.

Rider's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail \_\_\_\_\_

In the event emergency, medical aid/treatment is required due to illness or injury while participating in program functions or on program property, I authorize RHTS to:

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

This authorization includes x-ray, surgery, hospitalization, medication (including anesthesia), and any treatment procedure deemed "life saving" by the medical professional. This provision will be invoked only if the person listed below is unable to be reached.

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Medical Facility \_\_\_\_\_

Health Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Allergies \_\_\_\_\_ Seizures \_\_\_\_\_

Medications \_\_\_\_\_

**Non-Consent Option – If parent/guardian/self does not consent to above emergency procedures, and wishes alternate action taken, please state so here:**

\_\_\_\_\_  
NON-CONSENT SIGNATURE ONLY Photo Release Option: I  Do, I  Do not Consent to and authorize use and reproduction by RHTS of any and all photographs and any other audiovisual materials taken of my child/ward/myself for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.