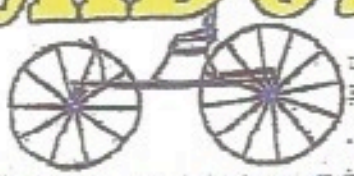
BUCKBOARD



THERAPEUTIC RIDING ACADEMY

Rider Name: _____ **Height:** _____ **Weight:** _____

Date of Birth: _____ **Age:** _____ **Special Needs:** _____

Address: _____

Parent/Guardian Names: _____

Address (if different from above): _____

Primary Phone: _____ **Secondary Phone:** _____

Release of Information: I hereby authorize _____(*medical care center, physician, therapist, etc.*) to release information from the records of (the *child*) _____ _____. The information is to be released to Buckboard for the purpose of developing a therapeutic riding program for the client of the above name. The information to be released is marked:

[ ] Medical History [ ] Speech Therapy [ ] Physical Therapy [ ] Occupational Therapy
[ ] Classroom Educational Plan [ ] Other:_____

Photo Release (Optional)

I hereby consent to and authorize the use and reproduction of any and all photos and other audiovisual materials taken of myself and/or the client in my care, for promotional printed material, educational activities, or any other use for the benefit of the program.

Parent Signature: _____ **Date:** _____

(308)672-6313 PO Box 654 Gering 140500 S. 14th Street Gering NE buckboardacademy@gmail.com