



# Reins of Life, Inc.

Therapeutic Horseback Riding

55200 Quince Road  
South Bend, IN 46619  
574/232-0853

9375 West 300 North  
Michigan City, IN 46360  
219-874-7519

Fax: 574/232-1104  
Website: [www.Reinsoflife.org](http://www.Reinsoflife.org)

## Visitor Registration

Name and Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

How did you hear about Reins of Life? \_\_\_\_\_

### Liability Release

As a visitor at Reins of Life, I acknowledge the risks and potential for the risks of a horseback riding program and related activities. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damage against Reins of Life, Inc., its Board of Directors, Instructors, Therapists, Volunteers, Equines, Employees, and/or the Operating Site for any and all injuries and/or losses I may sustain while visiting Reins of Life, Inc.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Signature of parent/ guardian if visitor is under 18 years of age.)

### Photo/Media Release/Website

I consent to and authorize the use and reproduction by Reins of Life, Inc. of any and all photographs and any other audiovisual material taken of me for promotional material, educational activities, exhibitions or for other use for the benefit of the program.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Signature of parent/guardian if volunteer is under 18 years of age.)

### Visitor's Authorization for emergency Medical Treatment & Consent

In the event, emergency medical aid/treatment is required due to illness or injury while visiting Reins of Life, Inc., I authorize Reins of Life, Inc. to secure and retain medical treatment and transportation if needed. 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 contact persons below are unable to be reached.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Signature of parent/guardian if volunteer is under 18 years of age.)

Print Name \_\_\_\_\_

### Person(s) to be contacted in case of an emergency:

1. Contact \_\_\_\_\_ Phone: \_\_\_\_\_

2. Contact \_\_\_\_\_ Phone: \_\_\_\_\_