ADULT RELEASE FORM

FOR RIDING AT
PREMIER STABLES, LLC

I, THE UNDERSIGNED, HEREBY AGREE TO ASSUME ALL RESPONSIBILITY AND RISK FROM THE USE OF RIDING HORSES WHILE TAKING LESSONS OR PARTICIPATING IN SHOWS OR TOURNAMENTS AT PREMIER STABLES, LLC OR ANY OTHER LOCATION WITHIN OR WITHOUT OF THE STATE OF KENTUCKY. THE RIDING INSTRUCTORS, TRAINERS AND ALL EMPLOYEES OF PREMIER STABLES, LLC SHALL BE HELD HARMLESS FOR ANY INJURY CAUSED TO ME OR ANY LOSS OF PROPERTY BY ME, UNLESS SUCH INJURY OR LOSS IS THE DIRECT RESULT OF THE WILLFUL AND WANTON NEGLIGENCE OF THE RIDING INSTRUCTOR, TRAINER OR EMPLOYEE.

IF I AM INJURED AND UNABLE TO MAKE DECISIONS FOR MYSELF, EVERY ATTEMPT SHALL BE MADE TO IMMEDIATELY LOCATE THE PERSON I HAVE LISTED BELOW. IF, HOWEVER IN THE OPINION OF THE RIDING INSTRUCTOR, TRAINERS OR AN EMPLOYEE, THE INJURY IS SUCH THAT IMMEDIATE ACTION IS REQUIRED, I AM NOT CAPABLE OF MAKING DECISIONS AND THE PERSON I HAVE LISTED BELOW CAN NOT BE REACHED, THE RIDING INSTRUCTOR, TRAINER OR EMPLOYEE HAS PERMISSION TO TRANSPORT ME TO AN APPROPRIATE MEDICAL FACILITY. THE RIDING INSTRUCTOR, TRAINER OR EMPLOYEE SHALL ATTEMPT TO REACH THE PERSON LISTED BELOW AS SOON AS POSSIBLE AND SHALL CONTINUE TO DO SO UNTIL REACHED OR, UNTIL I AM ABLE TO MAKE DECISIONS FOR MYSELF. I WILL PROVIDE PREMIER STABLES, LLC WITH ALL TELEPHONE NUMBERS WHERE THE PERSON LISTED BELOW MAY USUALLY BE REACHED.

BY SIGNING BELOW, I HEREBY GIVE CONSENT TO ANY X-RAY EXAMINATION, ANESTHETIC, MEDICAL OR SURGICAL DIAGNOSIS OR TREATMENT AND /OR HOSPITAL SERVICE THAT MAY BE RENDERED TO ME UNDER THE GENERAL OR SPECIFIC INSTRUCTIONS OF ANY PHYSICIAN OR HOSPITAL. FOR PURPOSES OF FACILITATING MY TREATMENT I WILL PROVIDE PREMIER STABLES, LLC WITH MEDICAL INSURANCE INFORMATION AND THE NAME AND PHONE NUMBER OF MY PRIMARY CARE PHYSICIAN.

IT IS UNDERSTOOD THAT THIS CONSENT IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT WHICH MAY BE REQUIRED, BUT IS GIVEN TO ENCOURAGE THE STAFF AT PREMIER STABLES, LLC, HOSPITAL STAFF AND PHYSICIANS TO EXERCISE THEIR BEST JUDGEMENT AS TO THE REQUIREMENT OF SUCH TREATMENT. I SHALL PAY ALL FEES FOR AMBULANCES, DOCTORS AND HOSPITALS AND ALL OTHER MEDICAL CHARGES REASONABLY OR NECESSARILY INCURRED ON MY BEHALF.

WARNING!

UNDER KENTUCKY LAW, A FARM ANIMAL ACTIVITY SPONSOR, FARM ANIMAL PROFESSIONAL OR OTHER PERSON DOES NOT HAVE THE DUTY TO ELIMINATE ALL RISKS OF INJURY OF PARTICIPATION IN FARM ANIMAL ACTIVITIES. THERE ARE INHERENT RISKS OF INJURY THAT YOU VOLUNTARILY ACCEPT IF YOU PARTICIPATE IN FARM ANIMAL ACTIVITIES.

KRS 247.4027

DATE_____
SIGNATURE_____

NAME IN PRINT_____
ADDRESS_____
CITY, STATE AND ZIP_____

HOME PHONE #_____
WORK PHONE #_____
CELL PHONE #_____
OTHER #'S_____

(PLEASE TURN OVER TO FILL OUT OTHER SIDE)

PERSON TO CONTACT IN AN EMERGENCY_____
ADDRESS_____
CITY, STATE AND ZIP_____
PHONE #_____
PHONE #_____

INSURANCE COMPANY_____
INSURANCE COMPANY PHONE #_____
POLICY #_____
PRIMARY CARE PHYSICIAN_____
TELEPHONE # OF PHYSICIAN_____
HOSPITAL OF CHOICE_____

Saved as ADLTREL
Under MS Word