



9140 La Madre * Las Vegas, Nevada 89149 * (702)-219-1728

Spirit Reins Application Packet

Confidentiality Agreement, Equine Activity Liability Release and Risk Acknowledgement

Confidentiality Agreement

By signing below, I agree not to disclose any client names, treatment or identifying information pertaining to any client, past, present or future of Spirit Therapies to anyone who is not affiliated with Spirit Therapies. This confidentiality agreement is effective the day of signing the agreement and is forever binding, even after my association with Spirit Therapies ends.

Equine Liability Release and Risk Acknowledgement

- Parties:** The parties to this agreement are Spirit Therapies and _____
(hereafter known as "client"). (child & guardian)
- Apportionment of Liability:** In consideration of client being allowed to attend, participate in, or observe activities sponsored or conducted by Spirit Therapies, or be present on the property on which Spirit Therapies conducts its activities, client does agree to hold harmless and release Spirit Therapies, its officers members, managers, agents, employees, representatives, assigns, affiliated organizations, insurers, and all others acting on Spirit Therapies' behalf and the owners of any horse or other property used by Spirit Therapies, from all claims, demands, causes of actions and legal liability, whether the same be known or unknown, anticipated or unanticipated, even if due to negligence and/or other clients acts or omissions. Client does further agree to waive all rights which may otherwise arise from an injury to client or client's property, and shall not bring any claims, demands, legal actions or causes of action against Spirit Therapies, those persons described above, or any person or entity, for any economic or non-economic loss due to bodily injury, death, or property damage arising out of the activities of Spirit Therapies or client's presence on or proximity to property used by Spirit Therapies.
- Indemnity:** Client agrees to be responsible for any and all damages, injuries or loss of life caused by client or a horse I the care, custody and control of client, and to indemnify Spirit Therapies and all parties described above, for any losses or expenses (including attorney's fees) which they incur in connection with claims related by client.
- Risks:** According to the North American Horseman's Association, numerous obvious and non-obvious inherent risks are always present in horseback riding and being around horses, despite all safety precautions. NO horse is a completely safe horse. Horses are 5 to 15 times larger, 20 to 40 times for powerful and 3 to 4 times faster than a human. If a client falls from a horse to the ground it will generally be at a distance of 3 to 5 feet, and the impact may result in injury to the client. If a horse is frightened or provoked it may divert from its training and act according to its natural instincts, which may include but are not limited to, stopping short, changing direction or speed at will, shifting its weight from side to side, bucking, rearing, biting, kicking or running from danger. These risks exist for any person around a horse, whether mounted or on the ground. Client acknowledges these risks and states that he/she is not relying on Spirit Therapies to advise of all the risks.



5. **Acknowledgment and Assumption of Risks.** Client acknowledges that he/she bears responsibility for his/her own safety and client should not participate in any client activity unless he/she is confident that he/she can do so safely. Participation in equine activities with or conducted by Spirit Therapies constitutes a knowing and voluntary assumption of all risks associated with equine activities involving Spirit Therapies or being present on or using Spirit Therapies property (including but not limited to inherent risks and the risk of negligence by Spirit Therapies or others) which is a defense under Nevada law to any claim for injury or damage, and a bar to recovery.

6. **Helmet Use.** Client acknowledges that wearing a properly fitted and secured client riding helmet which meets or exceeds the quality standards of the SEI Certified ASTM Standard F1163 while riding. Mounting, dismounting and being near horses may reduce the severity of head injuries or prevent death occurring as the result of a fall or other occurrence. Spirit Therapies makes no representation as to the condition, effectiveness or suitability of any helmet it may allow client to use. All helmet related risks are assumed by client.

7. **Visitors.** Should client bring to Spirit Therapies any person who is not a party to an Equine Activity Liability Agreement with Spirit Therapies, client agrees to educate them as to the risks of being around horses and horse operations, supervise them, be solely responsible for their safety and to be financially responsible for any injury or loss caused by or suffered by any such person.

8. **Safety Rules.** Client agrees to follow such rules for safety as are attached or are subsequently provided to them, or posted. Client acknowledges that failure to follow Spirit Therapies safety rules or the directions of Spirit Therapies staff, may put him/her at risk or, or increase the risk of personal injury.

9. **Premises Inspection.** Client has inspected the premises and facilities of Spirit Therapies and/or has in some other way satisfied himself/herself that the condition of the premises and facilities will provide an adequate and reasonable level of safety for client and guests, or visitors they may bring on the premises.

10. **Other Terms.** This document states the entire agreement between the parties as to liability and may not be changed, except in writing signed by the parties. The benefits of this agreement, including the release of legal liability, waiver of rights, indemnity and covenant not to sue, are intended to benefit others, including Spirit Therapies' officers, directors, members, managers, agents, employees, representatives, assigns, affiliated organizations, insurers, and all others acting on Spirit Therapies' behalf and the owners of any horses or other property used by Spirit Therapies. This agreement shall be binding upon Spirit Therapies, client, client's heirs and estate, when signed by the parties. If any clause, phrase or work is in conflict with State Law then that single part is null and void. This agreement and acknowledgment shall remain in force until terminated by client through written notice to Spirit Therapies at the address above. The District Court of Clark County Nevada shall be the exclusive venue for any litigation between parties described above.

Signature of Child's Parent/Guardian & Title

Date



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Spirit Therapies **Spirit Reins Summer Program Application Packet**

Child's name: _____

Parent/Legal Guardian's Name: _____

Address: _____

City: _____ State _____ Zip _____

Home Phone: _____ Cell: _____

Work Phone: _____ Ext. _____

Email Address: _____

Child's Age: _____ DOB: _____ Male _____ Female _____

School: _____

PHOTO RELEASE

I consent to and authorize the use and reproduction by Spirit Therapies of any and all photographs and any other audiovisual materials taken of me/my child for promotional material, educational activities, exhibitions or for any other use for the benefit of Spirit Therapies.

Client's Signature _____ Date _____

Print Name/Title _____



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Medical History, Emergency Information & Health Care Consent

Child's Full Name: _____ DOB: _____

Address: _____
Street City State Zip

Phone# H: _____ Work: _____ Cell: _____

Height: _____ Weight: _____ Tetanus Shot: Yes - date: ____ No ____

Medications:	Dosage	Taken Since	Prescribing Physician

Please check any medical issues; if yes please explain under comments.

Areas	Yes	No	Comments/Details
Auditory	___	___	_____
Visual	___	___	_____
Speech	___	___	_____
Cardiac	___	___	_____
Circulatory	___	___	_____
Pulmonary	___	___	_____
Neurological	___	___	_____
Muscular	___	___	_____
Orthopedic	___	___	_____
Allergies/Asthma	___	___	_____
Learning Disability	___	___	_____
Psychological Imp.	___	___	_____
Diabetes	___	___	_____

By signing this form, I, _____ (please print name) certify all information to be complete and true to the best of my knowledge.

Parent/Guardian's Signature: _____ Date: _____



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Medical History, Emergency Information and Healthcare Consent (cont'd)

Parent/Guardian: _____ Phone # _____

1st Emergency Contact: _____
Name Relationship Phone

2nd Emergency Contact: _____
Name Relationship Phone

(Please designate first choice to contact in emergency of you cannot be reached)

Emergency Medical Consent

The undersigned hereby grants to any Spirit Therapies affiliate, employee, intern, volunteer the authority to receive information pertaining to the emergency healthcare of the client named below and to make emergency healthcare decisions with respect to the child if the undersigned is unavailable to obtain such information or to make such decisions.

Child's Name: _____ Phone: _____

Address: _____
Street City State Zip

Date: _____ Signature: _____
Parent/Guardian

Emergency Medical Non-Consent

If the undersigned **does not** desire to grant any Spirit Therapies affiliate, employee, intern, volunteer information or to make healthcare decisions for the client if the undersigned is unavailable, please initial on the line below and state the procedures to be followed if the client becomes ill or is involved in an accident and the undersigned is unavailable.

_____ **I DO NOT CONSENT** to any Spirit Therapies affiliate, employee, intern, volunteer obtaining healthcare information or making any emergency healthcare decisions concerning the child.

Procedures to be followed:

Date: _____ Signature: _____
Parent/Guardian



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Spirit Reins Summer Program

Dates/Sessions/Rates

(Please check the box for the appropriate session)

_____ **Monday - Thursday June 10 - 13 8:30 am - 11:00 am \$250.00**
If payment is made by June 1 then the fee will be reduced by \$50

_____ **Monday - Thursday July 8 - 11 9:00 am - 12:00 pm \$250.00**
If payment is made by July 1 then the fee will be reduced by \$50

Siblings may ride for \$5.00.

I, _____ (name of guardian) of _____
(minor child) agree to pay Spirit Therapies at the rate listed above for the services provided to me for my child for whom I have legal responsibility. I understand that I am responsible for these charges.

Guardian's Signature

Witness Signature

Date

Date

Please make checks payable to Spirit Therapies and attach it to the completed application. To pay by Visa or MasterCard, please call our office at 702-219-1728. Please be aware that there is a \$5.00 extra charge for paying by credit card.

Full payment is required up front to secure a slot. If classes are full at the time this application is received your check will be returned and your child may be placed on a waiting list. Refunds for other reasons will be made minus a \$20 processing fee if there is a two-week prior notice. No refunds will be made if the child misses a day of classes.



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SPIRIT REINS Horse Professional Progress Notes

Date: _____ Client(s): _____

Animals involved in session (list any comments or concerns:

- ___ Buddy: _____
- ___ Do It: _____
- ___ Dusty _____
- ___ Gracie: _____
- ___ Harmony: _____
- ___ Honey Bear _____
- ___ Oliver: _____
- ___ Pablo _____

Activities/Equipment: _____

Observations: _____

Plan: _____

Signature: _____ Position: _____
Vol./Staff/Other

Print Name: _____