

**MARCODY RANCH, LLC
3804 PIONEER TRAIL
NEW SMYRNA BEACH, FL 32168
(386) 424-0123**

Website: www.marcody.com Email: hope@marcody.com

I acknowledge that I will engage in horseback riding and other equestrian activities at Marcody Ranch in New Smyrna Beach, Florida. I represent that I am experienced in horsemanship or it has been explained and I understand and accept that equestrian activities can be dangerous and hereby accept and assume all risks to my person and property incident to such activities.

I hereby waive, release and relinquish all rights and claims I may now or hereafter have against Marcody Ranch, LLC, Hope Rosenthal and Nicholas Psathas, owners of the land and building upon which it operates it's business, to any or all injury to myself, injury to my horse and damage to my personal property which may arise, directly or indirectly from my presence on said premises or my participation in such activities. This waiver and release shall bind me, my heirs and legal representatives.

Date: _____

Signature of Rider: _____
(Parent or Legal Guardian if rider under 18 years of age)

Print Name: _____

Rider's Name: _____ (Please Print)

Rider's Date of Birth: _____

Address: _____

Telephone: _____

Email: _____

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Minor Child **Photo Release**

I hereby consent to and authorize the use and reproduction by Marcody Ranch of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Signature: _____ Date: _____
Adult Signature: Parent or Legal Guardian for Minor Child

Rider Authorization for Emergency Medical Treatment

In the event emergency medical aid/treatment is required, due to illness or injury, during the process of receiving services or while being on the property of the agency, I authorize Marcody Ranch to:

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

I give consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. 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 person below is unable to be reached.

In an emergency, Contact: _____ Phone: _____

Contact: _____ Phone: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Policy: _____

Signature: _____ Date: _____
Adult Signature: Parent or Legal Guardian