



*Private Therapeutic Riding Facility Promoting,
work with rescued horses and other animals in
the treatment of people with emotional,
behavioral, social, mental, physical,
and/or spiritual needs*

(317) 371-7842

Face Book Page-Little Patch of Heaven Paints

Email-LPOHPaints@aol.com

Liability Release-Consent -Medical Release Form for the Barn Book

Dear Parent, Guardian, Participant, Volunteer, Employee, Visitor,

Welcome you and Thank you for visiting Little Patch of Heaven Paints.

I understand that during my or my child's visit to and participation in activities will involve a variety of activities on site as well as, off site in other locations.

I agree to release all liability & not to hold Little Patch of Heaven Paints , its staff, volunteers, or owners of properties used as temporary home, (6125 N. 400 E. Greenfield Indiana) responsible, in the event, of an accident or injury involving my child or myself.

I also agree, not to hold staff, volunteers, owners of vehicles, and/or owners of properties, responsible, during the time my child or I are being transported. This also includes, participating in activities linked to, or related to/from any and all various farms, activities, fundraisers, sponsorship drives, field trips, shows, rodeos and/or any other lesson, training sights. Specifically, but not limited to.... White Oak Stables, TD Farms, Diamond W Equine, varies pastures like 3200 N. 600 E.

I agree not to hold any of the above responsible in the event of an accident or injury involving my child or myself.

WARNING! Under Indiana Law, an equine professional is not liable for an injury to, or death of a participant, in equine activities resulting from the inherent risk of equine activities. As added by P.L. 290- 1995, SEC 1 IC34.

Print _____ Sign _____ Date _____



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I agree to wear a helmet when riding, that I am responsible for providing, at all times while mounted on a horse. _____ Initials

I give my permission for the staff /volunteer at Little Patch of Heaven Paints to seek the necessary medical attention for myself or my child in the event of an activity causing an injury. I also give my permission, to give over the counter Medications and to administer first aid if necessary.

Preferred Hospital _____

Insurance Co Name & Policy # _____

We hope that your visit is an enjoyable one and is one that you will remember as well as being a valuable learning experience.

And again Thank you! for visiting us.

We hope to see you back often.

Participants Signature _____ Date _____

Parents Signature _____ Date _____

Emergency Info to follow .

In Case of an Emergency

We hope to see you back often.

Name _____

Address _____

Phone _____

Email _____

Web Page _____ Face Book _____

Initials _____



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ICE Contacts

Name _____

Address _____

Phone _____

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