Capital Area Therapeutic Riding Association, Inc.
PO Box 339, Grantville, PA 17028   717-469-7517, fax 717-469-0095   www.catra.net

Individual Release Form

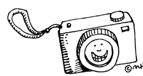
Name ______________________________ Date of Birth ____________ Date ______________
Address ____
City ________________________ County ______________________ Zip __________
Phone1 __________________ Phone2 __________________ Phone3 __________________
Email (PRINT)_________________________________   Please add me to the CATRA newsletter mailing

Liability Release

_________________________ would like to participate in the Capital Area Therapeutic Riding Association as a
volunteer name
volunteer. I acknowledge the risks and potential of risks of such a program. However, I feel that the possible benefits to myself/my son/my daughter/ my ward are greater than the risk assumed. I hereby intend to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Capital Area Therapeutic Riding Association, its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating as a volunteer in the Capital Area Therapeutic Riding Association.

Signature ______________________________________ Date ______________
(volunteer, parent or guardian)

Photo release (optional)



I hereby consent to and authorize the use and reproduction by Capital Area Therapeutic Riding Association of any and all photographs and any other audio/visual materials taken of me/my son/my daughter/ my ward for promotional material including printed materials, websites, social media sites, educational activities, exhibitions or for any use for the benefit of the program.

Signature ______________________________________ Date ______________
(volunteer, parent or guardian)

EMERGENCY CONTACT
Name_____________________________ Relationship ________________________
Home Ph.______________ Work Ph.______________ Cell Ph.______________

ANY KNOWN ALLERGIES OR MEDICAL CONDITIONS:
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