

**MINOR RELEASE FORM**  
**FOR RIDING AT**  
**PREMIER STABLES, LLC**

I (WE) THE UNDERSIGNED, THE PARENT(S) OR LEGAL GUARDIAN(S) FOR \_\_\_\_\_ A MINOR CHILD, 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 A RIDER OR ANY LOSS OF PROPERTY, UNLESS SUCH INJURY OR LOSS IS THE DIRECT RESULT OF THE WILLFUL AND WANTON NEGLIGENCE OF THE RIDING INSTRUCTOR, TRAINER OR EMPLOYEE.

IF A MINOR IS INJURED EVERY ATTEMPT SHALL BE MADE TO LOCATE THE PARENT(S) OR GUARDIAN(S) OF THE MINOR IMMEDIATELY. IF, HOWEVER, IN THE OPINION OF THE RIDING INSTRUCTOR, TRAINERS OR AN EMPLOYEE, THE INJURY IS SUCH THAT IMMEDIATE ACTION IS REQUIRED, THE RIDING INSTRUCTOR, TRAINER OR EMPLOYEE HAS THE PERMISSION OF THE UNDERSIGNED TO TRANSPORT THE MINOR TO AN APPROPRIATE MEDICAL FACILITY. THE RIDING INSTRUCTOR, TRAINER OR EMPLOYEE SHALL ATTEMPT TO REACH THE UNDERSIGNED AS SOON AS POSSIBLE AND SHALL CONTINUE TO DO SO UNTIL THE UNDERSIGNED IS REACHED. THE UNDERSIGNED WILL PROVIDE PREMIER STABLES, LLC WITH ALL TELEPHONE NUMBERS WHERE THE UNDERSIGNED IS LIKELY TO BE REACHED.

BY SIGNING BELOW, THE PARENT(S) OR GUARDIAN(S) OF THE MINOR HEREBY GIVE CONSENT TO ANY X-RAY EXAMINATION, ANESTHETIC, MEDICAL OR SURGICAL DIAGNOSIS OR TREATMENT AND/OR HOSPITAL SERVICE THAT MAY BE RENDERED TO A MINOR UNDER THE GENERAL OR SPECIFIC INSTRUCTIONS OF ANY PHYSICIAN OR HOSPITAL. FOR PURPOSES OF FACILITATING THE TREATMENT OF THE MINOR THE UNDERSIGNED WILL PROVIDE PREMIER STABLES, LLC WITH MEDICAL INSURANCE INFORMATION AND THE NAME AND PHONE NUMBER OF THE RIDER'S 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. THE UNDERSIGNED SHALL PAY ALL FEES FOR AMBULANCES, DOCTORS AND HOSPITALS AND ALL OTHER MEDICAL CHARGES REASONABLY OR NECESSARILY INCURRED ON BEHALF OF THE MINOR.

**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 \_\_\_\_\_  
PARENT OR GUARDIAN SIGNATURE \_\_\_\_\_

MINOR'S NAME IN PRINT \_\_\_\_\_  
MINOR'S ADDRESS \_\_\_\_\_  
CITY, STATE AND ZIP \_\_\_\_\_  
MINOR'S DATE OF BIRTH \_\_\_\_\_

**(PLEASE TURN OVER TO FILL OUT OTHER SIDE)**

MOTHER'S NAME IN PRINT \_\_\_\_\_  
FATHER'S NAME IN PRINT \_\_\_\_\_

HOME PHONE # \_\_\_\_\_  
PARENT OR GUARDIAN WORK PHONE # \_\_\_\_\_  
PARENT OR GUARDIAN CELL PHONE # \_\_\_\_\_  
PARENT OR GUARDIAN OTHER PHONE #'S \_\_\_\_\_  
PARENT OR GUARDIAN E-MAIL ADDRESS \_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY, STATE AND ZIP \_\_\_\_\_  
PHONE # \_\_\_\_\_  
PHONE # \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_  
INSURANCE COMPANY PHONE # \_\_\_\_\_  
POLICY# \_\_\_\_\_  
PRIMARY CARE PHYSICIAN \_\_\_\_\_  
TELEPHONE # OF PHYSICIAN \_\_\_\_\_  
HOSPITAL OF CHOICE \_\_\_\_\_