



Current Date: \_\_\_\_\_

\_\_\_\_ Student    \_\_\_\_ Faculty/Staff    \_\_\_\_ Visitor/Guest

## RELEASE OF LIABILITY AGREEMENT

**The student, rider or guardian must sign this form before permission will be given to participate in the activity.**

I recognize there are risks, including those of injury and even death, in all of the activities initiated and carried out under the auspices of the Asbury University Equine Program. I freely assume those risks on my own. I agree to release and hold harmless from liability the Asbury University Equine Program, its staff, volunteer workers, and other employees and agents in the event of injury or death of myself or dependent, resulting from negligence or any other theory of liability while engaging in any Equine Program activity. I agree to not make any claim or file any lawsuit against Asbury University or the Equine Program for injuries or damages related to my, or my dependents, participation in any activity. (Please initial \_\_\_\_\_)

I understand that this is a legally binding contract and that the Equine Program activities are provided in consideration for this signed Release of Liability Agreement.  
(Please initial \_\_\_\_\_)

**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.

I have carefully read this release of liability and fully understand its contents. I am aware that this releases Asbury University Equine Program from liability, and I sign it of my own free will.

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature of Legal Adult or Guardian

\_\_\_\_\_  
Effective date: present date through  
graduation or activity date

Names of Participating Minors:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(continued on back)**

## EMERGENCY MEDICAL RELEASE AGREEMENT

In the event a medical emergency should occur, the Director and staff will make every effort to contact parents in order to approve hospital emergency room care. In the event we are unable to do so, we ask that you sign this release for emergency room treatment.

I acknowledge that I / my child \_\_\_\_\_,  
(Print Name)

be taken to \_\_\_\_\_ seeking treatment.  
(Preferred Hospital)

I hereby authorize the physicians in attendance to employ emergency treatment as they deem necessary for the above-named person. I also authorize the release of information for the purpose of payment to the hospital and the treating physicians.

\_\_\_\_\_  
Printed Name of Authorized Signer

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

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## PHOTO RELEASE AGREEMENT

I hereby give permission to Asbury University to use my name and photographic likeness in all forms and media for advertising, trade, and any other lawful purposes.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If Participant is under 18:

I, \_\_\_\_\_, am the parent/legal guardian of the individual named above,  
I have read this release and approve of its terms.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**ASBURY UNIVERSITY**  
*Academic Excellence & Spiritual Vitality*