

DREAM THERAPIES

366 E. Mesa Verde Ln., Las Vegas, NV, 89123

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CONSENT FOR TREATMENT AND RELEASE OF LIABILITY

As the parent or legal guardian of _____(full name)_____ (hereafter "my child") I am hereby giving my voluntary consent for my child to participate in Dream Therapies' Occupational Therapy, Physical Therapy and/or Therapeutic Riding program.

1. I have informed myself of the policies, procedures and methods employed by Dream Therapies, and consent to the use thereof in providing treatment for my child.

I acknowledge that it is my responsibility to inform my child's physician that my child is participating in this treatment. I confirm that my child's physician is aware of my child's participation in occupational therapy and/or therapeutic riding. I voluntarily request Dream Therapies provide treatment for my child.

2. Assumption of Risk

I acknowledge the risks/potential risks of engaging in Dream Therapies therapy program, which are similar to risks of play, activities of daily living and equestrian activities if we opt to participate in that portion of the program. Participants and their parents/legal guardians need to be aware that some of the risks involved in this activity include, but are not limited to:

the propensity for an equine to behave in ways that may result in injury, loss and in rare instances death to persons on or around an equine, the unpredictability of an equine's reaction to sounds, sudden movement, unfamiliar objects, persons or other animals, and a collision with another animal, person or object(s).

After considering the inherent risks, I feel that the possible benefits to me and my child, are greater than the possible risks. I voluntarily assume the risk for my child.

3. Waiver of Liability

I hereby, as parent or legal guardian, intending to be legally bound, for my self, my heirs and assignees, executors or administrators, waive and release forever any and all claims for damages against Dream Therapies, its Board of Directors, therapists, instructors, volunteers, employees, referring entities, subcontractors, property owners upon whose land the services are conducted, for any and all injuries and/or losses I or my child may sustain while voluntarily participating in Dream Therapies' occupational and/or therapeutic riding program.

4. Health History

I understand that Dream Therapies wishes to take reasonable steps to maintain the safety and well-being of its participants. I confirm that I have disclosed all medical conditions of my child that may be affected in any way by the treatment. I acknowledge that I am responsible for updating this release if the medical condition of my child changes.

I acknowledge that I have been given sufficient time to ask questions, if any, concerning the nature and scope of this agreement. I have read the entire agreement and agree to it.

Signature and printed name of client/client's parent/legal guardian Date

Signature and printed name of witness Date