Dreams Go On with High Hopes
Therapeutic Horseback Riding Program
Lake View Stables 1403 Turkey Valley Road
Hollidaysburg, PA 16648
www.DreamsGoOn.com

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize_____(person or agency) to release information from the records of _____(rider) to Dreams Go On, for the purpose of developing goals and objectives for a therapeutic horseback riding program. The information to be released is marked below.

_____ Medical History

_____ Physical Therapy evaluation and assessment

_____ Occupational Therapy evaluation and assessment

_____ Speech Therapy evaluation and assessment

_____ Classroom Individual Education Plan

_____ Other: _____

Signature of Parent or Guardian: _____

Date: _____

In the event emergency/medical treatment is required due to illness or injury during a riding session or while on the property, I authorize Dreams Go On, Inc. Staff to provide the appropriate basic medical treatment.

Parent or Guardian: _____

Please send the indicated material to: Dreams Go On Debbie Kelly, Program Manager 1006 Valley View Blvd Altoona, PA 16602