Shady Hollow Assisted Riding
Registration Form

959 E Main St
Birdsboro, Pa 19508

610-582-4050
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www.hugahorse.com

Select a Program:

	Summer Camp		Bridle Club		Hippotherapy
	Assisted Riding Lessons		Program Volunteer		Boarder
	Able Riding Lessons		Non Program Volunteer		Little Breeches

Name: ____

Home Address: ______________________________ City: ________ State: ____ Zip: ______________

Email Address: ____

Cell Phone: ______________________________ Home Phone: ______________________________

Work Address: ______________________________ City: ____________ State: _______ Zip: ___________

Age______ Weight:_____If under 18, Parents Names: ____

School: ____

Instructor: ____

Photo Release:

I consent to and authorize the use and reproduction by ***Shady Hollow Assisted Riding*** of any photographs and audio-visual materials taken of me for promotional material, educational activities, and exhibitions to benefit the program.

Date: ________ Signature: ____

Date: ________ Parent/Guardian Signature: ____

Liability Release:

To participate in any program at ***Shady Hollow Assisted Riding***, I acknowledge the risks and potential for risks of horseback riding and associated activities. However, I feel that the possible benefits are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors and administrators, waive and release forever all claims for damages against ***Shady Hollow Assisted Riding & Shady Hollow Farms,*** it's owners, board of directors, instructors, therapists, volunteers and/or employees for any and all injuries and/or losses that may be sustained while participating in ***Shady Hollow Assisted Riding's*** programs.

For this privilege I have read and agree to comply with all rules posted on the property and agree to wear an ASTM/SEI approved helmet.

Date: ________ Signature: ____

Date: ________ Parent/Guardian Signature: ____

Medical History:

Do you have any medical conditions that would limit your activities? (circle one) Yes No

Do you have any health problem or allergies that we should know about in case of an emergency?

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury during the process of volunteering, or while being on the property, I authorize SHADY HOLLOW ASSISTED RIDING to:

1. Secure and retain medical treatment and transportation if needed.
2. Release volunteer records upon request to the authorized individual or agency involved in the medical emergency treatment.

Emergency Contact Information:

Name: ______________________________ Phone: ______________________

Relationship: ______________________________

Physician Contact Information:

Name: ______________________________ Phone: ______________________

Preferred Medical Facility: ______________________________

Health Insurance Co.: ____________________ Policy #: ____________________

CONSENT PLAN

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person listed below is unable to be reached.

Date: ________________ Consent Signature: ______________________________

Print Name: ______________________________

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of volunteering or while being on the property. In the event emergency treatment/aid is required, I wish the following procedures to take place:______________________________

____

Date: ________________ Consent Signature: ______________________________

Print Name: ______________________________

Would you like to be kept informed of upcoming events, lessons, classes and fundraisers at Shady Hollow? Yes/No

Email:______________________________