

EQUI-VENTURE EQUESTRIAN CENTRE



*EQUI-VENTURE at Gypsy Hill Stables • 1444 Brown Road • Westminster, MD 21158
443.898.2772
www.Equi-VentureEquestrian.com*

PROGRAM PARTICIPANT

PARTICIPANT'S NAME: _____

PARTICIPANT'S BIRTHDATE: _____

PARENT'(S) NAME: _____
(IF APPLICABLE)

ADDRESS: _____

HOME PHONE: _____

CELLULAR PHONE: _____ **Okay for Texting:** _____

OTHER PHONE NUMBER(S): _____

EMAIL ADDRESS: _____

How did you hear about our equestrian centre? _____

A PARENT OR GUARDIAN (IF APPLICABLE), MUST BE PRESENT AT ALL RIDING LESSONS/PROGRAM ACTIVITES. THE ONLY EXCEPTION IS IF THEY HAVE A CELLULAR PHONE & AN EMERGENCY CONSENT FORM HAS BEEN COMPLETED.

*****CANCELLATION OF LESSONS / PROGRAM ACTIVITIES MUST BE DONE 24 HOURS PRIOR TO APPOINTMENT TIME TO AVOID PAYMENT OF THE FULL LESSON/PROGRAM ACTIVITY FEE. NO ONE WILL BE EXCUSED FROM THIS POLICY UNLESS A DOCTOR'S NOTE IS PRESENTED*****

Please Sign

EQUI-VENTURE EQUESTRIAN CENTRE



PROGRAM PARTICIPANT BACKGROUND INFORMATION

PLEASE CHECK OFF THOSE THAT APPLY:

- Never Ridden Pony Ride Lead Line Trail Ride Camp
- Been Around Family/Friend's Horse Taken Lessons Before Shown

PREVIOUS INSTRUCTION INFORMATION or RIDING EXPERIENCE

If applicable, please describe any previous riding experience? _____

Is program participant currently taking lessons? _____

If riding instruction is currently being provided or was given in the past, please list current or previous instructors and/or stables currently riding at or stables that were ridden at:

What disciplines of riding were and/or being taught? _____

What was achieved at these lessons? _____

Did /does participant enjoy these lessons? _____

Why or why not? _____

Did /does participant enjoy the disciplines of riding taught? _____

Why or why not? _____

OVER

What level would participant's current or previous instructor place student at? _____

Has participant and/or parents if applicable, reviewed our EVEC lesson program/activity program curriculum and policies?

If applicable, does the participant want to transfer his/her lessons to our stable? _____

Have our EVEC Horsemanship Levels been read by the participant / parents if applicable? _____

After reviewing our Horsemanship Levels, what level is best for the participant to be placed in? _____

Does participant have any fear issues or had a bad experience with horses? _____

If so, please describe: _____

Has participant ever fallen off a horse or pony? _____

If so, please describe: _____

Any injury as a result of being around horses? _____

If yes, please describe: _____

What disciplines or riding style(s) does the participant want to be taught now? (May choose more than one.)

What is the participant's goal for riding or what level does he/she want to achieve? _____

Is the participant interested in competing at horse shows? _____ If so, at what level? _____

Is the participant interested in the EVEC working student or apprentice programs? _____

Is participant interested in 4-H for horses, the United States Pony Club, or our riding clubs or our stable activities at this farm? _____

If so, which ones? _____

Is the participant interested in possibly purchasing/adopting/leasing his/her own horse now or in the future?

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MEDICAL INFORMATION

Does student (rider/participant/guest) have any vision or hearing problems? If yes, please describe.

Is student (rider/participant/guest) current on his/her tetanus vaccination? _____

Does student (rider/participant/guest) have any medical condition, disease or taking medication that emergency medical personnel would have to know about? If yes, please describe.

Does student (rider/participant/guest) have any drug allergies? If yes, please describe.

Does student (rider/participant/guest) have any other allergies to animals, insect bites or stings, food, materials, etc.? If yes, please describe.

Does student (rider/participant/guest) have any physical condition or limitation that may affect his/her riding ability and/or balance, or that the instructor should be aware of? If yes, please describe.

Does student (rider/participant/guest) have any mental, emotional and/or behavior condition or learning disability that may affect his/her riding ability or that the instructor should be aware of? If yes, please describe.

Are there any other concerns the instructor/stable manager/guide/leader) should be aware of?
If yes, please describe.

EQUI-VENTURE EQUESTRIAN CENTRE



USE OF NAME AUTHORIZATION

U I DO...

U I DO NOT...

consent to and authorize the use and reproduction by EQUI-VENTURE Equestrian Centre of my/my minor child's name for promotional material, newsletters, educational activities, exhibitions or for any other use for the benefit of the program.

Signature of Student or Participant

Date

Signature of Guardian if Student or Participant is a minor

Date

PHOTO/ AUDIO-VISUAL AUTHORIZATION

U I DO...

U I DO NOT...

consent to and authorize the use and reproduction by EQUI-VENTURE Equestrian Centre of any photographs and any other audio-visual materials taken of me/my minor child for promotional material, newsletters, educational activities, exhibitions or for any other use for the benefit of the program.

Signature of Student or Participant

Date

Signature of Guardian if Student or Participant is a minor

Date

EQUI-VENTURE EQUESTRIAN CENTRE



CONSENT TO EMERGENCY MEDICAL, DENTAL, OR SURGICAL TREATMENT FOR MYSELF OR MINOR CHILD

My name is _____ . (Please check which statement applies below).



I am a riding student, rider, guest and/or a participant of an EQUI-VENTURE EQUESTRIAN CENTRE event or activity **OR**



if applicable, I am the (mother, father, guardian) of _____, a minor child and a riding student, rider, guest and/or a participant of an EQUI-VENTURE EQUESTRIAN CENTRE event or activity.

I hereby consent to any medical, dental, or surgical treatment or procedure of an emergency nature that is reasonably necessary to save the life of myself or the life of the minor child named above, or to restore myself or the child to health. I understand that should medical emergency treatment be required, the current insurance information listed below will be provided to the attending clinic or hospital to cover current or future payments of incurred bills. (It is my responsibility to notify EQUI-VENTURE EQUESTRIAN CENTRE of any changes of this information). If I do not have insurance to cover any part of or all of the incurred bills now or in the future, I agree to be financially responsible for these bills.

Medical Information:

Health Problems/Medical Conditions: _____

Allergies: _____

Current and/or Recent Medications: _____

Insurance Policy Information:

Policy: _____

Policy Number: _____

Insured's Name: _____

Emergency Phone Numbers:

Number	Person To Contact	Number	Person To Contact
_____	(Doctor)	_____	(Relative)
_____	(Dentist)	_____	(Relative)

(Signed) _____ (Date) _____

NOTARY:

SWORN TO AND SUBSCRIBED before me this _____ day of _____, in the year _____.

_____ Notary Public in and for the State of _____.

My Commission Expires: _____.