



## RIDING CAMP REGISTRATION

Student's Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex (*circle one*): M F

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

1st Parent/Guardian's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

2nd Parent/Guardian's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

**If you marked yes on any of the above questions, you must submit a clarification letter with your registration form.**

I approve this registration and certify that the student is capable of such an experience. I understand that summer camp registrations are not refundable without a doctor's authorized medical reason (this excludes behavioral or psychological issues).

I grant permission for the student to participate in all planned riding activities. In case of accident or illness, Cornerstone Farms is authorized to secure emergency medical treatment. Prudent attempts will be made to contact the parents immediately. I understand the related expenses for this medical attention will be (my) the parent's responsibility. Cornerstone Farms is not responsible for lost, stolen or damaged personal articles. I also authorize Cornerstone Farms to have and use photographs, slides and/or video of the student named on this registration as may be needed for promotional purposes and website session photos. I agree to waive any claims against Cornerstone Farms and its volunteers for injuries or damages that may result from the conduct of other persons including participants in riding academy programs.

**Parent/Guardian Signature** (*Required*):

\_\_\_\_\_ **Date:** \_\_\_\_\_

# Release and Hold Harmless Agreement

## David and Cortland Hendrick/Cornerstone Farms

**WARNING: Under the Equine Activity Liability Act, each participant who engages in an equine activity expressly assumes the risks of engaging in and legal responsibility for injury, loss, or damage to person or property resulting from the risk of equine activities.**

Whereas, the undersigned acknowledges the inherent risks of engaging in equine activity including, but no limited to such activities as riding, training, assisting in medical treatment of, driving, or being a passenger upon an equine, whether mounted or unmounted, or assisting a participant, being in close proximity to or working around horses and understands the possibility of injury to both rider and horse in normal use or in competition or schooling, and

The undersigned is aware of the risks of engaging in equine activities (as specified above and in the above Illinois Equine Liability Act), including, but not limited to:

1. The propensity of an equine to behave in dangerous ways that may result in the injury, harm, or death to the participant.
2. The inability to predict an equine's reaction to sound, movement, objects, persons, or animals.
3. The hazards of surface or subsurface conditions.
4. Collisions with other equines or objects, and
5. The potential of a participant to act in a negligent manner that may contribute to injury to the participant or others, such as failing to maintain control over the animal or not acting within his or her ability.

In consideration, therefore, for the privilege of riding and/or working around horses at Cornerstone Farms or any other property owned by the Stable, or any property adjoining, the undersigned does hereby agree to **hold harmless and indemnify David & Cortland Hendrick/Cornerstone Farms**, their agents and employees, and further releases them from any liability or responsibility for accident, damage, injury, including death, or illness to the undersigned or to any property or to any horse owned by the undersigned or to any family member or spectator accompanying the undersigning for any reason on the premises of Cornerstone Farms.

Please circle:                      Lessons                      Summer Camp                      Volunteer                      Guest

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

Person voluntarily entering into this Release and Hold Harmless Agreement:

Signature: \_\_\_\_\_ Name (Print): \_\_\_\_\_

Address: \_\_\_\_\_ Phone No. \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

If person is a minor (under 18), the signature of a parent or legal guardian is required.

Signature: \_\_\_\_\_ Name (Print): \_\_\_\_\_

# HEALTH FORM

Name \_\_\_\_\_  
Gender \_\_\_\_\_ Age as of January 1, 2012 \_\_\_\_\_  
Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Camper's Social Security # \_\_\_\_\_  
Parent or Guardian \_\_\_\_\_  
Day Phone (\_\_\_\_) \_\_\_\_\_  
Evening Phone Number (\_\_\_\_) \_\_\_\_\_ Cellular Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_  
street & number city state zip

## Health History: *To be completed and signed by parent*

Keep a copy for your records to record changes in your child's health status. Notify Cornerstone Farms in writing if there are changes.

**Allergies:** Check those, which apply to this camper.

- This camper has no known allergies.
- This camper has an allergy to the following food(s): \_\_\_\_\_.
- This causes anaphylaxis? Yes No

Describe the reaction if this food is eaten and what is done to manage it:

\_\_\_\_\_

This camper is allergic to the following medication(s): \_\_\_\_\_

This camper is allergic to the following substance(s): \_\_\_\_\_

This causes anaphylaxis? Yes No

Describe the reaction and what is done to manage it (attach additional information if needed):

\_\_\_\_\_

**Chronic Concerns:** Check all that pertain to this camper and provide information about supportive health care.

This camper has no chronic health concerns and is capable of full participation in this program.

This camper has the following chronic health concern(s):

- Asthma
- Headaches
- Narcolepsy
- Diabetes
- Menstrual Cramps
- Frequent ear infections
- Frequent colds
- Incontinence
- Other (please describe)

\_\_\_\_\_

Provide information about supportive health care needed for each checked item:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medication:** Provide complete information. Bring enough medication to last the entire session. ALL medications MUST be in pharmacy containers and appropriately labeled.

This camper does not take any medication.

This camper takes routine medication (include vitamins) as follows (attach more information if needed):

#1 Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ How often each day? \_\_\_\_\_ Reason for taking: \_\_\_\_\_

#2 Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ How often each day? \_\_\_\_\_ Reason for taking: \_\_\_\_\_

#3 Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ How often each day? \_\_\_\_\_

Reason for taking: \_\_\_\_\_

**General History:** Check "Yes" or "No" for each statement.

This camper has had chicken pox..... Yes No

This camper has had mononucleosis in the past 12 months..... Yes No

This camper's hearing is within normal range..... Yes No

This camper uses contact lenses (consider bringing an extra pair) or glasses to correct vision..... Yes No

This camper has an illness, injury or surgery, which would affect program participation..... Yes No

For girls: This camper knows about menstruation and/or has a normal menstrual history..... Yes No

This camper has been hospitalized..... Yes No

This camper has or has had seizures..... Yes No

Please explain any "yes" answers.

Name of camper's physician: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

Name of camper's orthodontist: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

**Mental and Emotional Health:** Check "Yes" or "No" for each statement.

This camper has been diagnosed with Attention Deficit Disorder (ADD) or AD/HD..... Yes No

This camper has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder..... Yes No

This camper has or has had an eating disorder ..... Yes No

This camper has an emotional health concern..... Yes No

This camper has a learning disability..... Yes No

This camper has seen or is currently seeing a professional to address mental / emotional health concerns..... Yes No

**What have we forgotten to ask?** Provide additional information about your child's health, which may have been neglected, on this form. We are particularly interested in information that impacts upon your child's ability to fully participate in our program. Provide additional information about your child's health, if needed, by attaching a page to this form.

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**Billing Information for Health Care:** Parents/Guardians are financially responsible for health care given by an out-of-camp provider. To whom should we route charges for this camper's health care? **Include a copy of an insurance card if appropriate. Copy both sides of the card so addresses and telephone numbers are available.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

**Parent Contact Information:** We will call in an emergency or if we have questions about your child. Provide contact information for other people who know your child and with whom we can consult if we cannot reach you. We assume you have spoken with these individuals and they are willing to assist should the need arise.

Parent/Guardian Daytime Evening

Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

Alternate Relationship

Contact: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

to Camper: \_\_\_\_\_

Alternate Relationship

Contact: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

to Camper: \_\_\_\_\_

**Parent/Guardian Authorization for Health Care:** This health history is correct, and the person described has permission to participate in all camp activities except as noted by me and/or the examining physician. I give permission to the physician selected by Cornerstone Farms (CSF), or any agent and employee of CSF, to order X-rays, routine tests and treatment for the health of my child. If I cannot be reached in an emergency, I give permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for the child. This form may be photocopied. CSF and its agents and employees have permission to obtain a copy of my child's health record from the providers they access to treat my child. I understand that information about my child's health will be shared on a "need to know" basis with other Staff.

**Signature of Custodial Parent/Guardian:**

\_\_\_\_\_ **Date:** \_\_\_\_\_