



Equine Adventures Participant Enrollment Packet

Date of Equestrian Adventures Week: _____

Rider Name: _____ DOB: _____ Age: _____
Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Emergency Contact: _____ Phone: _____

Email: _____

How did you hear about our summer program: _____

Parents or Guardians: _____

Address/Phone (if different from above): _____

Summer Equestrian Adventures Payment Guidelines:

- Payment must be received before registered week of Equestrian Adventures.
- Current riders with a remaining balance are not eligible to register for Summer Equestrian Adventures unless the balance is paid in full.
- **NO REFUNDS WILL BE GIVEN AFTER ADVENTURES WEEK BEGINS.**

Summer Equestrian Adventures Riding Guidelines:

- Riding lesson content includes: safety, grooming, ground handling, tacking, correct body position while riding, harmony with the horse and confidence building. Riders may not mount from the ground; they use a mounting ramp/block.
- For safety reasons, we do not allow observers in the arena or stable area during classes, but let us know if you would like to take photos of your favorite rider in a lesson.
- Every rider in every class must wear properly fitting ASTM/SEI approved helmets. Riders must wear long pants that reach the ankle when riding and they must wear sturdy closed toe/heel shoes.
- Each rider must have updated Participant Enrollment packet forms on file in the office.
- "Horse Play" will not be tolerated in the stable or arena area.
- Riders need to put their equipment away after grooming and riding.
- Positively no alcoholic beverages allowed on the property.
- Smoking is allowed only in the designated smoking area across the road by the round pen. No smoking close to the barn.

I agree to abide by the above written guidelines. I understand that if payment in full is not received on or before the first day of Equestrian Adventures, my rider will not participate in class and will forfeit participation in said week.

I understand and agree that the Participant Enrollment packet forms are valid for the current camp season only. It is my responsibility to provide Star with any changes or updates during this period.

Signature: _____
Parent/Guardian

Date: _____



June 19th – 23rd
June 26th – 30th
July 24th – 28th
August 7th – 11th
August 21st – 25th

The rate for Star Summer Equestrian Adventures is \$320.00 per rider per week. Riders must be between 6 and 13 years of age to attend.

Hours are Monday – Friday from 9:30 a.m. until 3:00 p.m. No child care before or after.

LIABILITY RELEASE:

I understand and acknowledge that equine activities involve risk of serious injury, including permanent disability and death. However, I feel that the benefits to my child are greater than the risks assumed. I hereby certify that I know of no medical problems that would increase my child's risk of illness or injury as a result of participation in any activity associated with Star Therapeutic Equestrian Center.

In consideration of my participation in the Star Therapeutic Equestrian Center Summer Equine Camp program and/or use of the facilities provided by Star Therapeutic Equestrian Center, Star Community®, I expressly agree and contract, on behalf of myself, my heirs, executors, administrators, successors and assigns, that Star and its insurers, employees, officers, directors, and associates, shall not be liable for damages arising from personal injuries (including death) sustained by my child, in, on, or about the premises as a result of the use of the facilities. By the execution of this agreement, I accept and assume full responsibility for any and all injuries, damages (both economic and non-economic), and losses of any type, which may occur to my child and I hereby fully and forever release and discharge Star Therapeutic Equestrian Center, its insurers, employees, officers, directors, and associates, from any and all claims, demands, damages, rights of action, or causes of action, present or future, whether the same be known or unknown, anticipated or unanticipated, resulting from or arising out of the participation in and /or use of said programs and facilities.

Signature: _____
(Parent or Guardian)

Date: _____

Printed Name: _____

PHOTO/MEDIA RELEASE

_____ DO _____ DO NOT

I hereby consent to and authorize the use and reproduction by Star Community®/Star Summer Equestrian Adventures of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Signature: _____
(Parent or Guardian)

Date: _____



Emergency Medical Treatment Form

In the event emergency medical aid and/or treatment is/are required due to illness or injury, I authorize Star Community®/Star Therapeutic Equestrian Center to:

1. Secure and retain medical treatment and transportation if needed; and,
2. Release relevant client records to the authorized individual or agency involved in the medical emergency treatment.

Participant Name: _____ Phone: _____
Address: _____

Emergency Contact: _____ Phone: _____

Alternate Emergency Contact: _____ Phone: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Policy #: _____

Consent Plan

This authorization includes, but is not limited to, X-rays, surgery, hospitalization, medication and/or any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) listed above is/are unable to be reached.

Date: _____ **Signature:** _____
Parent or Guardian

Printed Name: _____ Phone: _____
Address: _____

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury. I expressly agree to indemnify and hold Star Therapeutic Equestrian Center harmless against any and all claims, demands, damages, rights of action, or causes of action that may arise from injuries sustained as a result participating in Star Therapeutic Equestrian Center activities. In the event emergency treatment/aid is required, I request the following procedures to take place:

Date: _____ **Signature:** _____
(Parent or Guardian)

Printed Name: _____ Phone: _____
Address: _____

Medical Data Sheet

Medications: _____

Possible Side Effects: _____

ALLERGIES:

Medications: _____
Environment: _____
Foods: _____
Animals/Insects: _____

Seizure Activity:

Describe in detail type of seizure: _____

Behavior Concerns: _____

Ambulation Concerns: _____

Seeing/Hearing Impairment Concerns: _____

Communication Concerns: _____

Other: _____
