2019 Working Equitation Obstacles Clinic

Registration Form
High Horses Therapeutic Riding Program

Clinician: Amanda Lamoureux

Name:________________________________ Telephone:_______________

Address:____

E-mail: ________________________ Join our mailing list? Y N Already On

Date: Sunday-February 3, 2019 9-4:00

- Participant Fee $125.00 (membership to New England Working Equitation included)
- Participant Fee $100.00 (High horses staff and currently active volunteers & Current members of NEWE)
- Auditor Fee $ 20.00
- Stall Fee $ 20.00

Bring Your Own Lunch

Mail completed forms and payment (Payable to High Horses TRP) to:

High Horses Therapeutic Riding Program
P.O. Box 278 Sharon, Vermont 05065
802-763-3280 or program@highhorses.org

Please send equine vaccination & proof of coggins to Amanda at wenortheast1@gmail.com

Facility Physical Address: 138 Horse Farm Road Sharon, Vermont

Total cost of Participation $__________
Total cost for Stall $__________
Total cost of Auditing $__________
Total Due $__________

Cancellation Policy

Fees are non-refundable but fully transferable to an individual of your choosing

If we have to cancel due to weather we will reschedule the clinic with funds transferable to new date

High Horses
Therapeutic
Riding Program

Liability Release

Under Vermont Law, an equine activity sponsor is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities that are obvious and necessary, pursuant to 12 V.S.A. § 1039.The Undersigned assumes the unavoidable risks inherent in all horse-related activities, including but not limited to bodily injury, physical harm, or death to horse, rider, and spectator.

I understand that use of an ASTM/SEI certified helmet and proper footwear are required at High Horses Therapeutic Riding Program and strongly encouraged for all horse related activities elsewhere, and personally accept all consequences for my decision to wear or not wear them.

Do you have any physical, mental or emotional issues that would prohibit or inhibit your abilities to safely participate in any part of this event? No Yes If yes, please explain: ____________________

____

Are you on any medications that would prohibit or inhibit your ability to safely participate in any part of this event? No Yes If yes, please explain: ____

____

Name/Contact Info for nearest relative____

What are your personal goals in regards to working with or riding horses?

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____

How did you hear about us? Website ~ Newsletter ~ Word of Mouth ~Flyer ~ Facebook ~ Magazine Ad

What Source? _____________________________

May we share event photos that you may be in on our website or for advertising without your name?
Yes No

Date:______ Participants Printed Name:____

would like to participate in the High Horses Therapeutic Riding Program. I acknowledge the inherent risk and potential for risks of equine activities. However, I feel that the possible benefits to me/my son/my daughter/my ward are greater than the risk assumed.

Address:____

Phone#: Home ________________________ Cell _________________________Age if a minor: ____

E-Mail (Please print clearly)____

Signature:____

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Parent/Guardian Signature (if under 18yrs):____