Vintage Valley Sporthorses LLC

Summer Equestrian Camp

ENROLLMENT FORM

STUDENT'S NAME: (Last)_____ (first)_____ (DOB)_____.

PARENT/GUARDIAN

Name(s) _____ Relationship to Student: _____.

Address _____ City, State _____.

Zip _____ Email: _____.

Home Phone _____ Cell _____ Work _____

EMERGENCY CONTACT INFORMATION

Contact 1: _____ Relationship: _____.

Phone: Hm:_____ Cell:_____ Wk:_____.

Contact 2: _____ Relationship: _____.

Phone: Hm:_____ Cell:_____ Wk:_____.

Physician: _____ Phone: _____.

Health Insurance Company: _____ Policy:# _____.

Allergies or Special Medical Instructions: _____

_____

_____.

Emergency Care Authorization Signature: _____.

I understand that horseback riding is a high-risk sport. I hereby release and hold harmless the instructors, trainers, employees, and owners of Vintage Valley Sporthorses LLC and BW Farm LLC from all liability from accidents, damage, injury, or illness to horses, owners' employees, attendants, spectators, or any other persons or property- **WARNING**: Under Virginia law, an equine professional is not liable for an injury or the death of a participant in equine activities resulting from the inherent risks of equine activities.

Both parents / guardians MUST sign this release form:

Signature: _____ Date: _____

Signature: _____ Date: _____

Witness: _____

Print name: _____

Vintage Valley Sporthorses LLC

Medical/Emergency Treatment Consent

I, _____, hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment, by medical doctors, hospitals or their authorized designees, as may in their professional judgment be necessary to provide for the medical, surgical or emergency care of my _____ _____.
(relationship)(hereafter "dependent") – Full Name

I further give my consent to Vintage Valley Sporthorses Owners or Members, (hereafter known as VVS Team), who will be caring for my dependent for the period _____ through _____, to arrange for routine or emergency medical care and treatment necessary to preserve the health of my dependent. In the event that my dependent is injured while under the care of Vintage Valley Sporthorses LLC, Team, I hereby give permission to the VVS Team to provide first aid for said dependent and to take the appropriate measures, including contacting the Emergency Medical Service (EMS) system and arranging for transportation to the nearest emergency medical facility.

In making medical decisions on my behalf for the benefit of my dependent, I direct that the caregiver attempt to contact me. However, if medical care becomes essential, I give permission to VVS Team to make such decisions regarding such treatment as deemed appropriate by the medical doctor, hospital or their authorized designee. In furtherance of any treatment decisions to be made by the caregiver on my behalf for the benefit of my dependent, I authorize the VVS Team to request, obtain, review and inspect any and all information bearing upon my dependent's health and relevant to any such decisions to be made respecting such treatment.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on the condition of my dependent and that I am responsible for all reasonable charges in connection with the care and treatment rendered to my dependent during this period.

_____ _____
Signature of Legal Guardian Date

_____ _____
Name Name of dependent

_____ _____
Address Date of Birth

_____ _____
Phone Allergies

_____ _____
Health Insurance Carrier Date of last tetanus booster

_____ _____
Health Insurance Policy # and Group # Current Medications

_____ _____
Personal Care Physician

_____ _____
Address Witness Signature

_____ _____
Phone Name Date

Vintage Valley Sporthorses LLC

Summer Equestrian Camp
Medical information and release

CAMPER: _____

Camp Session Date: _____

PARENT/GUARDIAN INFORMATION **EMERGENCY CARE AUTHORIZED:** _____
Name(s) _____ **Relationship to Camper:** _____
Address _____ **City, State** _____
Zip _____ **Email:** _____
Home Phone _____ **Cell** _____ **Work** _____

EMERGENCY CONTACT:
Contact 1: _____ Phone: _____
Contact 2: _____ Phone: _____

PHYSICIAN AND MEDICAL INFORMATION
Physician: _____ Phone: _____
Health Insurance Provider: _____ Policy: _____
Allergies or Special Medical Instructions: _____
_____