

The Village Farm

HORSE CAMP REGISTRATION

RETURN THIS FORM WITH DEPOSIT TO:

The Village Farm Attn: Summer Camp
2020 Woodbourne Road
Langhorne, PA 19047

RIDER'S NAME _____ AGE: _____ M/F _____

PARENT NAME _____ DAYTIME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT _____ RELATION _____ PHONE _____

WHICH CAMP? (circle one) Purple (DAY CAMP) Green - 2'3" minimum (2 HR BLOCK LESSONS)

SPECIAL NEEDS/ALLERGIES _____

PLEASE READ CAREFULLY BEFORE SIGNING: If participant has any medical problems that may worsen or be aggravated by horseback riding; a medical certificate from you doctor MUST be presented before you can participate. Check with your doctor before this or any physical activities especially if you have not participated in a physical activity for a period of time. It is recommended that participants check with their doctor and be current with tetanus shots.

TERMS: There will be no refunds or make up days for camp once registered. There will be a 10% fee for returned checks. The Village Farm does not assume responsibility for lost or stolen items on the premises. Purple Camp Hours are from Monday - Friday 9:00am - 3:30 pm and Green Camp Hours are Monday - Thursday 10:00am - NOON and Friday 10:00 am - 2:00 pm. Prompt pick up is appreciated. Campers should bring their own lunch and drinks except on Friday. Refrigerator is available. Campers must wear their own helmet and wear long pants and shoes with a heel while riding. Preferred clothing: riding breeches, half chaps and paddock boots.

In consideration of being permitted to participate in this activity, I Hereby for myself, my heirs, my personal representatives, assume any and all injuries that may be associated with this activity. I certify that I am in proper physical condition to participate in the activity without risk of serious injury. I further waive any claims against and release, discharge, covenant not to sue and hold harmless The Village Farm, and Pineway Equestrian Center, LLC, its officers, members, sponsors, staff, or other representatives, any cooperating and coordinating individuals or agencies and any other successor and assign, in connection with any and all injuries, illness or damages of any kind whatsoever whether caused by negligence or other fault of the above agencies.

I also give permission for the free use of my name and picture by the above agencies in any and all media, in broadcast, or other account.

I understand all the above and I understand that this is a contract and I intend to be legally bound for my child or myself.

Participant's Signature _____ Date: _____

Parent Signature _____ Date: _____

\$100 DEPOSIT IS DUE ALONG WITH COMPLETED REGISTRATION FORM. REMAINING PAYMENT IS DUE BY 1st DAY OF CAMP. MAKE CHECKS PAYABLE TO R. BELMONT.

The Village Farm

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR WHEN
LEGAL GUARDIAN and/or PARENT(S) IS UNABLE TO BRING PATIENT

I, _____, parent or guardian of
_____, a minor, do hereby
authorize the following name(s);

a. Rebecca Belmont

b. Kevin Belmont

as my agent(s) to consent to any x-ray examination, anesthesia, medical evaluation and/or treatment, surgery evaluation and/or treatment, diagnosis or care which is deemed advisable by and is to be rendered under, the general or special supervision of a licensed physician. This authorization includes hospital admission if such is deemed necessary by the physician. It is understood that this authorization is given to provide authority and power on the part of my aforesaid agent(s) to give specific consent to any and all such evaluation, diagnosis, office treatment, anesthetic administration or surgical treatment(s) which a physician, in the exercise of his/her best judgement, may deem advisable.

This authorization also grants to my agent(s) the power to sign for release of information to any third party payers who may be responsible for part or all of the cost of the services provided. This authorization shall remain effective from ____/____/____ to ____/____/____, unless sooner revoked in writing delivered to said agent(s).

____/____/____

Date

Signature of parent, guardian

PATIENT INFORMATION FOR MINOR LISTED PRIOR

Patient's Name: _____ Date of Birth: ____/____/____

Home Address: _____

Current Medication(s): _____

Allergies: _____

Parent or Guardian Name(s): (1) _____

Relationship _____

(2) _____

Relationship _____

Primary Insurance Company: _____

Person Who Carries This Insurance: _____

Address (if different than above): _____

Insurance ID Number: _____ Group Number: _____