



Therapeutic Riding Program

SUMMER CAMP 2017

DATE OF SESSION: August 2nd, 3rd and 4th, 2017
TIME: 8:30 am to 1:00 pm
COST: \$250

Name of Rider: _____

Address: _____

Phone: _____ email: _____

If different than above:

Legal Guardian: _____

Address: _____

Phone: _____ email: _____

I am registering the above rider for the above noted session. All the appropriate forms have been completed, signed, submitted and are on file with CDSCL.

Mandatory forms:

- Rider Application/Profile Form
- Liability Release/Waiver
- Photograph/Video Release/Non Consent Form
- Authorization/Non Authorization for Emergency Medical Treatment
- Emergency Profile
- Physician Referral Form (Must be updated if condition has changed)

Forms where applicable and/or required:

- Intake/Referral for Services
- For riders with Downs Syndrome - Atlanto-axial X-Ray Verification
- Consent for release of information

Signature of Rider: _____ **Date:** _____

Signature of Legal Guardian: _____ **Date:** _____

Signature of Witness: _____

Signature of Program Director: _____ **Date:** _____

Questions? Please call Michelle at 250-402-6793 or email mwhiteaway@hotmail.com

Please returned the completed form to
The Office - 205 7th Ave North, Creston
OR By Mail - PO Box 1820, Creston, BC V0B 1G0
OR By fax: 250-428-2297
Thank you!