2024 Summer Program Registration

SUMMER PROGRAM PARTICIPANT INFORMATION

Participant's Name: _____ Age: _____ DOB: _____

Parent/Legal Guardian: _____

Phone Number: _____ Parent/Guardian Email: _____

Address: _____ State: _____ Zip: _____

Please select desired week:

____ July 08 - July 12 Horses, Horses, Horses! ($450.00)
____ July 15 - July 19 Neigh'bor Summer Program ($450.00)
____ July 22 - July 26 Touch a Horse! ($450.00)

A non-refundable deposit of $100.00 per camp is required to hold the camper's place.

- Participants registered in **two** or more weeks of camp will pay $350.00 for each additional week after week one.
- Siblings participating in the **same** week of camp will pay $350.00 after first registrant sibling is billed regular camp rate.

Total Amount: $_____

To get more information & register call 908-735-5912, or email programs@ridingwithheart.org

CAMP INFORMATION

Camp operates Monday-Friday 9:00-1:00 rain or shine. You must provide snacks and drinks for your child. While riding, all campers are required to wear a helmet, long pants, and closed toe, sturdy shoes (no sandals or crocs). RWH has helmets and boots to use for riding.

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CONTACT INFORMATION

Parent/Legal Guardian Name: _____

Emergency Contact Phone: _____

Secondary Contact Name: _____

Secondary Emergency Best Contact: _____

List authorized adults who may pick your child up:

_____

_____

How did you learn about the program: _____

LIABILITY RELEASE

I / my child would like to participate in the Riding with HEART program. I acknowledge the potential risks of horseback riding and working around horses. However, I feel the possible benefits to me / my child are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors, or administrators, waive and release forever all claims for damages against Riding with HEART, its Board of Directors, Affiliated Organizations, Employees, Instructors, Therapists, Aides, Volunteers, Equines and Operating Site for any and all injuries and/or losses I/ my child may sustain while participating in Riding with HEART activities.

WARNING: UNDER NEW JERSEY LAW, AN EQUESTRIAN AREA OPERATOR IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ANIMAL ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ANIMAL ACTIVITIES, PURSUANT TO P.L. 1997, C.287, C:5:15-1 ET ESQ.

Print Name: _____

Signed: _____Date: _____

(Signature of parent/guardian if participant is under 18 years of age)

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PARTICIPANT AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Participant Name: _____Birth Date: _____

Parent/Legal Guardian Name: _____

EMERGENCY CONTACT:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Physician's Name: _____ Medical Facility: _____

Health Insurance Company: _____ Policy Number: _____

Allergies: (medications and other): _____

Current Medications: _____

_____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the Riding with HEART, I authorize RWH Program to:

1. Secure and retain medical treatment and transportation if needed.
2. Release pertinent records upon request of the authorized individual or agency involved in the medical emergency treatment.

CONSENT PLAN

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the emergency contact(s) above is (are) unable to be reached.

Consent Printed Name: _____

Consent Signature: _____ Date: _____
(Signature of parent/guardian if participant is under 18 years of age)

OR…

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NON-CONSENT PLAN

I **do not** give my consent for emergency medical treatment/aid in the case of illness or injury while I/my child participate in Riding with HEART. In the event emergency treatment/aid is required, I wish the following procedure to be followed:

_____

_____

Non-Consent Printed Name: _____

Non-Consent Signature: _____ Date: _____
(Signature of parent/guardian if participant is under 18 years of age)

HEALTH INFORMATION

Describe abilities/difficulties in the following areas below (include assistance required):

Physical Abilities (please include medical diagnoses if applicable): _____

_____

Social/Behavioral/Cognitive: _____

_____

MEDICAL CLEARANCE BY PARTICIPANT'S PHYSICIAN:

Your patient, _____ would like to participate in supervised equestrian activities at Riding with HEART. Please complete below.

To my knowledge, there is no reason why this person cannot participate in supervised horseback riding, and unmounted equine-assisted activities.

Name/Title: _____ Lic. /UPIN No: _____

Signature: _____ Date: _____

Address: _____ Phone: _____