

Horse Around Day Camp

REGISTRATION FORM

Name: _____ Address: _____ City: _____
Phone Home: () _____ Work: () _____ Cell: () _____ Age: _____
Parent(s) Name(s): _____ E-mail Address: _____

Please check the week or weeks desired for the **DAY CAMPERS**.

JUNE 28-JULY 2 _____ JULY 5-9 _____ JULY 12-16 _____ JULY 19-23 _____ JULY 26-30 _____
AUG 2-6 _____ AUG. 9-13 _____ AUG. 16-20 _____ AUG. 23-27 _____

Please check if you will be riding the SHUTTLE _____.

(Limited seating space is available on the shuttle and is on a **FIRST COME BASIS!**)

PLEASE LIST ANY ALLERGIES OR MEDICATION TO BE TAKEN: _____

All medication and written instructions must be given to Camp Director.

(Written proof of immunization and a physical within 2 years is needed with application form.)

PHONE NUMBER IN CASE OF AN EMERGENCY: () _____ Contact Person: _____

RISKS OF EQUINE ACTIVITIES.

Under New Hampshire Law a participant in Equine activities assumes the risk of any injury, harm, damage or death and any legal responsibility that may occur to participant from the inherent risks associated with equine activities. Pursuant to RSA 508.19 equine Professionals ARE NOT LIABLE FOR DAMAGES RESULTING FROM THE INHERENT.

In case of an emergency while participating in the camp, permission is given for physicians to perform needed treatment. I will assume all financial obligation incurred.

DOCTOR'S NAME: _____ PHONE #: _____ INSURANCE CO: _____

PARENTS SIGNATURE: _____ DATE: _____

Special Instructions: _____

Please send a \$150.00 deposit for each child for each week of DAY CAMP this will be **NON-REFUNDABLE** with **NO EXCEPTION! BALANCE TO BE PAID TWO WEEKS PRIOR TO ARRIVAL.** Please Read Carefully all the Information on previous page to answer all your Questions.

MAIL CHECKS TO: HORSE AROUND DAY CAMP
24 Currier Rd.
Candia N.H. 03034

CAMP HEALTH & IMMUNIZATION for DAY CAMP	
Name:	_____
Address:	_____
Most recent complete exam within 2 year	Date: _____
Most recent Tetanus Toxoid within 10 years	Date: _____
Other immunization up-to-date?	_____
	yes no
Medical problems-specify:	_____
Allergies:	_____
Medication:	_____
Limitations, restrictions	_____
	Date: _____
PHYSICIAN'S SIGNATURE	_____