



# Miracles In Motion

*“Transforming lives, one ride at a time.”*

## 2011 Winter Horsemanship Camp Registration Form

To be completed by parent/guardian

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_\_ M/F \_\_\_\_\_  
 HOME ADDRESS: \_\_\_\_\_ City: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Parent/Guradian: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name of person(s) who will transporting child to and from camp:

Morning drop off: \_\_\_\_\_ Afternoon Pick-Up: \_\_\_\_\_  
 Morning drop off: \_\_\_\_\_ Afternoon Pick-Up: \_\_\_\_\_

I, \_\_\_\_\_, parent/guardian of the above named child, understand that he/she can only be released to the above named individuals, and that no other person(s) will be allowed to transport my child to or from the MIM facility without prior consent given to the camp Director(in person). In the event that you need to arrange for an alternate pick-up for your child (via telephone) during camp hours, you must provide MIM with a password. This password will be used to confirm identity of the individual picking up your child.

Password \_\_\_\_\_ (maximum 8 characters). \_\_\_\_\_ Parent/Guardian Initials

### Health History

Does your child have any health related issues (physical/mental) that may impact their ability to participate in camp activities? If yes, please

explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If your child has physical, emotional, cognitive and/or behavioral health related issues, a health form MUST be completed by your child’s physician prior to the first day of camp. Current MIM riders with medical forms on file are exempt from this requirement.

Allergies: (Food, drug, Insect stings, Plants, Animals, Other) \_\_\_\_\_  
 \_\_\_\_\_

Medications (please list; include dosage & reason for taking):

Medication	Dosage	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Activity Permission**

I give permission for this camper to participate in all activities described for the program in which he/she is registered and all other activities deemed appropriate for the camp (Below) unless otherwise noted:

Please initial

\_\_\_\_ Classroom activities    \_\_\_\_ Barn Chores (filling buckets, stall cleaning, sweeping)    \_\_\_\_ Outdoor Activities  
\_\_\_\_ Horse Handling (leading & grooming)    \_\_\_\_ Horseback Riding

If you would like additional information about any of these activities prior to giving permission, please call 603-357-7282.

In addition, this camper may not participate in the following activities: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**LIABILITY RELEASE**

\_\_\_\_\_ (Rider's Name) would like to participate in the therapeutic riding program of Miracles In Motion. I acknowledge the risks and potential for injury inherent in horseback riding. However, I have decided that the possible benefits to myself/my son/my daughter/my ward 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 Miracles In Motion, it's Board of Directors, Instructors, Therapists, Aides, Volunteers, agents, facility and horse owners and Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in the therapeutic riding program of Miracles In Motion.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Rider, Parent, or Guardian

**PHOTO RELEASE: OPTIONAL**

I hereby consent to and authorize the use and reproduction by Miracles In Motion of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Rider, Parent, or Guardian

**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services or while on the property being used by the Program, I authorize Miracles In Motion to:

- 1. Secure and retain emergency medical treatment and transportation.
- 1. Release medical records upon request to the authorized individual or agency involved in the medical emergency treatment.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_