PO Box 172, Ridgway, PA 15853
www.bigmaplefarmnt.net
bmfntinc@gmail.com
(814) 387-3571

Dear Friend,

Thank you for your interest in Big Maple Farm's Natural Therapies, Inc's Riding Lesson Program! BMFNT is excited to bring this opportunity to children and adults desiring to learn more about riding horses. Riding students will have the ability to meet weekly with an instructor for one hour or a half hour and learn skills starting from their level and up.

Registration Information, Parent/Student Release - these can be completed by you. Please sign where indicated and feel free to go into as much detail as needed.

Participant Medical History- to be completed by the person most familiar with the participant. Sign these as necessary.

A non-refundable registration fee of $10.00 is payable to BMFNT, INC. The fee is to be submitted with the registration, and it is indicated on the form. The registration fee will be used to supplement current administrative costs, program insurances, as well as any equipment needs for riders.

We are looking forward to working with your family throughout these riding lesson classes. If you have not had the chance to visit the program, please call for an appointment at 814-387-3571. We would welcome the opportunity to show you around! Please do not wait for us to call you. If you have any other questions do not hesitate to call or email us at bmfntinc@gmail.com.

Sincerely,

Amanda Balon
Executive Director BMFNT

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PARTICIPANT REGISTRATION INFORMATION

Participant's Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____County:_____

Parent/Legal Guardian: _____Phone:_____

Parent email (please print): _____

Parent employer: _____

Emergency Contact (name and number): _____

Additional Emergency Contact (name and number): _____

School District: _____ School Attending: _____

Participant's Physician/Medical Center: _____Phone:_____

Physician's Address: _____

Allergies: Yes _____ No _____ If yes, please list

_____

_____

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LIABILITY RELEASE _____ (Participant's name) would like to participate in the Big Maple Farm's Natural Therapies, Inc.'s Regular Riding Lesson program. I have discussed the risks and problems of horseback riding, on ground horsemanship skills, and on ground small animal skills with my own/son's/daughter's/ward's doctor and acknowledge the risks and potential for risks in this activity, however, I feel 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 Big Maple Farm's Natural Therapies, Inc. & Painted Sky Stables, its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward and immediate family may sustain while participating in the Big Maple Farm's Natural Therapies, Inc. Programs.

Date: _____ Signature: _____

Relationship: _____
(self/mother/father/ Legal guardian)

Witness: _____
(Must be a board member when turning form in) – Thank you for your cooperation!

PHOTO RELEASE: OPTIONAL I [**PLEASE CHECK ONE:**
CONSENT _____ DO NOT CONSENT _____] to and authorize the use and reproduction by Big Maple Farm's Natural Therapies, Inc. 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: _____
(client, parent, or guardian)

PLEASE NOTE: If you are unable to make your lesson please inform BMFNT at least 1 hour before scheduled time. If you are 10 minutes late for your lesson time or you are a no show, you will still be required to pay for that lesson time.
_____ Initial to allow staff know you read and understand.

.

***** Would you like to be included in Quarterly Newsletter Emails from BMFNT? (Circle) Yes/No***

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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 being on the property of the agency, I authorize BMFNT to: 1. Secure and retain medical treatment and transportation if needed. 2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Participant's Name: _____

Phone: _____ Address: _____

Zip: _____

In the event I cannot be reached, please contact:
(1): _____ Phone: _____

(2): _____ Phone: _____

Physician's Name: _____

Phone: _____

Preferred Medical Facility: _____

Health Insurance Co.: _____

Policy #: _____

___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 person listed below is unable to be reached.
Date: _____ Consent Signature: _____

Volunteer, parent, or guardian Print Name: _____

Phone: _____ Address: _____Zip_____

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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 during the process of receiving services or while being on the property of the agent. In the event emergency treatment/aid is required, I wish the following procedures to take place:
Date: _____ Non-Consent Signature: _____

Volunteer, parent, or guardian Print Name: _____

Phone: _____ Address: _____Zip_____

ATTACH A COPY OF THE COMPLETED MEDICAL HISTORY.

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Participant Medical History Form

NAME OF PARTICIPANT _____ DATE OF BIRTH _____

NAME OF PARENT/GUARDIAN_____ HOME PHONE _____

WORK PHONE _____

IN CASE OF EMERGENCY CONTACT PARENTS FAMILY DOCTOR _____

/OR _____PHONE _____ OFFICE PHONE _____

Medical Insurance Plan No.:

_____

A. **Please note any health problem, physical handicap, emotional difficulty, behavioural problem, or facts which may limit full participation in the summer day camp.**

_____

B. **Student's immunization shots are current , i.e. tetanus**

YES (__) NO (__)

C. **Student is subject to:**

__ asthma	__ sensitive skin		__ nosebleed
__ ear ache	__ sinus trouble	__ convulsions	__ high blood pressure
__ fainting	__ nightmares	__ headache	__ motion sickness
__ tonsillitis	__ bronchitis	__ kidney problem	__ allergies (describe)
__ eye infection			

D. Student wears contact lenses or glasses (please circle one)

E. **Medications**: I would like my child to be given,

Name of Medication(s) _____

Purpose of Medication _____

****

In case of emergency, I hereby give permission to the physician selected by the BMFNT to provide necessary treatment for my child.

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Parent/Guardian signature: _____ Date: _____