

Declaration of Fitness to Ride

I hereby declare that I am physically fit, I do not, and have not suffered from any of the following conditions, which I understand may lead to dangerous situation with regard to other persons or myself during riding activities.

Epilepsy, allergies, fits, severe head injury, recurrent blackouts or giddiness, disease of the brain or nervous system, high blood pressure, lung or heart disease, recurrent weakness or dislocation of any limb, diabetes, mental illness, drug or alcohol addiction, recent back injury, arthritis and severe joint and sprains, chronic bronchitis, asthma, rheumatic fever, thyroid adrenal or other glandular disorder, recent blood donation or any condition that requires the regular use of drugs.

I hereby declare that I have no physical or mental condition that should preclude me from participating in my chosen activity, that I am not participating against medical advice or treatment and that I have not been diagnosed by a registered doctor as having a terminal illness.

I further declare that in the even that I feel ill or unwell, have any physical complaints whatsoever or if an injury is sustained of any kind during the course of riding activities, I will notify the instructor/guide/employee of the insured immediately and before moving away from t he immediate vicinity.

I have read the above Declarations, understand them, and I agree to be bound by them.

Signature of Adult Participant Name of Adult Participant (Please Print) Date

Address of Adult Participant Contact Number

Signature of Parent/Guardian Name of Parent/Guardian (Please Print) Date
if Participant is a Minor, and by
their signature, they on my behalf
release all claims that both they and
I have

Address of Parent/Guardian Contact Number

Name of Minor (Please Print) Date

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If you cannot sign the above declaration because of any of the above conditions, you must notify the Instructor/Guide/Employee of the insured immediately before you mount the horse or commence any activities.
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Attention of the Authorized Insured Only (Counter-Sign upon full and correct completion)

Counter-Signature of Authorized Insured Name of Authorized Insured (Please Print) Date