



**X-Country
Schooling
May 24th, 2008
At
Cedar Crest
Farm**

**Cedar Crest Farm
Equestrian Center**

2054 Route 83, Pine Plains, NY 12567
equisport@taconic.net

Name of Rider _____ Number of Horses _____
 Level/s _____ Trainer _____
 MHDCTA Members \$25.00 _____ Non-Members \$30.00 _____
 Pre-register with payment by May 12th, 2008 Preferred time AM/PM _____

Send to: Carol Swanson, 82 Moadock Rd., Millerton, NY 12546 (845) 489-1620
 All riders must have a trainer, if a trainer is not available Cedar Crest Farm can supply one. Please email swanson.mc@gmail.com for information.

- Beginner Novice – Training level X-Country fences
- 1 hour schooling, groups of 3 or more 1 ½ hours
- Variety of jumps as each level, no water jump

RELEASE (must be completed for all clinics)

I understand that horse back riding, and in particular jumping, is a high-risk sport and I am participating in this clinic at my own risk. I hereby assume this risk, and further do hereby release and hold harmless MHD&CTA, the Organizer, the Organizing Committee, judges, officials and all volunteers, the host and property owners from all liability for negligence resulting in accidents, damage, injury, loss or illness to myself and to my property, including the horse I will ride in this clinic. I understand appropriate headgear must be worn at all times while the horse is being exercised or ridden.

Rider's signature _____ Date: _____
 Parent's signature, if rider is under 18 years of age: _____

EMERGENCY MEDICAL RELEASE FORM (for use by minor participants – optional)

If emergency medial care is required for _____
(name of participant)

In conjunction with this clinic and if normal permission is not available in a timely manner, the undersigned authorizes appropriate emergency medial care as deemed necessary by emergency medial personnel, a physician or the medial facility providing treatment.

Related Information:
 Parent/Guardian/Contact: _____ Phone#: _____
 Address: _____
 Family Physician: _____ Phone#: _____
 Participant is allergic to: _____
 Participant takes the following medications/for: _____
 Medical Insurance Company: _____ Policy # _____

I have read this entire medical release and agree to it:
 _____ Date: _____
 Signature of Parent or Guardian