

# Orienteering Clinic Registration Form

Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

Horse's Name \_\_\_\_\_

Coggins # \_\_\_\_\_

Do you allow your picture to be used on Social Media or other public venues?

Yes                      No

In the event emergency aid/treatment is required due to illness/injury during this clinic by Laura Martlock while on the property of 1011 Little Calfpasture Hwy, Swoope, VA 24479, I authorize Laura Martlock 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 treatment.
3. This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the emergency contact person listed below is unable to be reached.

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

Print Name \_\_\_\_\_ Phone: \_\_\_\_\_

In case of emergency, Contact:

\_\_\_\_\_ Phone: \_\_\_\_\_

I recognize that horseback riding involves some risk of injury which, under certain circumstances, could cause death, and to that end, I release and discharge Laura Martlock, her spouse, heirs and assigns, from any claim or cause of action I, my son/daughter, spouse or ward may have against her, her heirs, spouse, or assigns, except for actual negligence arising out of injury to myself while engaging in this horseback riding clinic.

\_\_\_\_\_ Participant Signature