Foxfield Riding School Summer Camp

APPLICATION FOR ENROLLMENT ~ 2017

P.O. Box 3576
1250 E. Potrero Rd.
Westlake Village, CA 91359
(805) 495-5515
Fax (805) 497-1799
www.foxfield.com
ride@foxfield.com

Name _____
last first nickname

Birthdate _____ Age on June 1, 2017 _____
month day year

Home Address _____

City _____ State _____ Zip Code _____

Home telephone ( ) _____

Cell ( ) _____

Telephone number at which legal guardian or parent may be reached in case of emergency ( ) _____

Parent Email address: _____ Camper Email Address:

Height of student _____ Weight _____

State any health and/or food problems, allergies _____ Vegetarian ($95) Yes No

Date of last Tetanus shot _____

List of medications student will be taking while at camp _____

Who recommended Foxfield to you? _____

Has student had any previous riding experience? Yes _____ No _____ Do you jump? _____ How high? _____

If yes, please check all applicable Western Saddle _____ English Saddle _____ Bareback _____

Please outline riding experience (lessons, shows, etc.).We would love to know the name of your trainer or barn (optional). Use back of sheet if necessary for full description.

In an emergency, if parent or legal guardian cannot be reached, may one of the Foxfield Riding School Staff take student to a doctor of our choice?_____. Do you give your consent to emergency medical treatment in the event you cannot be reached?_____. Do you give consent to Children's Tylenol or Ibuprofen being administered in the event you cannot be reached? _____.

Please complete mandatory information on page 2 and attach copy of insurance card.

May student attend and participate in all activities on or off the property of Foxfield Riding School? _____

What session did student attend at Foxfield last year? _____ Which riding group? _____

Please list any favorite horses _____

Is student bringing her own horse? _____ (Facilities are limited. Reservations must be made at this time.)

Please note: A vet certificate stating that all shots are current must be supplied to office before session starts.

Do you have a friend coming to Foxfield at the same time? Please name and say whether you would like to room together.

Please check session(s) desired and enclose $300.00 deposit for each ( )1st ( )2nd ( )3rd ( )4th

Is Burbank (Bob Hope) Airport pick-up desired?_____ Camper should arrive at airport between **12 noon-2:00pm** on Sunday. Campers will be taken to airport between 9:00-11:00 am, depending on flights, the day after the session ends. Please notify Foxfield of flight arrangements two weeks before start of session.

NO REFUNDS AFTER MAY 1st *****FOXFIELD IS NOT RESPONSIBLE FOR LOST TACK OR CLOTHING*****

I have sufficient knowledge of horses to understand their unpredictability and potentially dangerous character in general and I understand that the use, handling and riding of a horse ALWAYS involves risk of bodily injury to anyone who handles or rides horses, as well as the risk of damaging the property of others. I understand that any horse, irrespective of its training and usual past behavior and characteristics, may act or react unpredictably at times, based upon instinct or fright, which likewise is an inherent risk assumed by one who handles/rides horses. I expressly assume such risk and hereby waive any claims that I might have against Foxfield Riding School, its Teachers, Counselors and Trainers, on behalf of the above mentioned camper or myself. I agree to pay all doctor or hospital fees if the child is injured while staying at Foxfield.

Date _____ _____ _____
Signature of Parent or Legal Guardian Printed Name

CAMPER'S NAME: _____

PARENT NAME: _____

YOUR APPLICATION WILL BE RETURNED IF THIS INFORMATION IS NOT COMPLETE

INSURANCE INFORMATION

IN CASE OF MEDICAL OR SURGICAL EMERGENCY, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE CAMP DIRECTOR TO SECURE PROPER TREATMENT FOR, AND HOSPITALIZE IF NECESSARY, THE CAMPER LISTED ON THIS APPLICATION. EVERY EFFORT WILL BE MADE TO CONTACT THE PARENT OR GUARDIAN SHOULD SUCH AN EMERGENCY ARISE.

ALL SUCH EXPENSES WILL BE THE RESPONSIBILITY OF AND SHALL BE PAID FOR BY THE PARENT(S) OR LEGAL GUARDIAN

PLEASE PROVIDE THE FOLLOWING INFORMATION (print or type):

FAMILY DOCTOR: _____ **PHONE:** ( ) _____

DO YOU HAVE HEALTH AND ACCIDENT INSURANCE? _____

NAME OF INSURANCE COMPANY: _____

PHONE NUMBERS: _____

AGENT (if known): _____

ADDRESS: _____ **CITY** _____ **ST** _____

POLICY OR GROUP NUMBER: _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN: _____

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