Participant Registration

Participant Name: _____ Date of Birth: _____

Home Address: _____

City, State, ZIP: _____

Primary Phone: _____ Other Phone: _____

Email: _____

Complete the following if you are being sent to this certification clinic by a camp, stable, or organization:

Sponsoring facility/organization: _____

Address: _____

City, State, ZIP: _____

Contact Person: _____ Phone: _____

Certification Requirements:

■ I have read the Certification Levels description for this CHA certification type and understand the requirements for achieving each level of certification.

Certification Goals: What do you hope to accomplish by attending this certification clinic? Do you have any special interests or issues that you would like to see covered? _____

_____

_____

Experience: Briefly describe your background and experience with horses. Include the type of riding you may have done, horse management experience, any experience in teaching riding, other teaching experience, and interests. _____

_____

_____

Upcoming Plans: If you will be working in the equine industry in the near future, please describe the type and size program you plan to work with and what your duties will be. _____

_____

_____

Photo Release: I ■ do ■ do not grant Certified Horsemanship Association permission to use my likeness in a photo, video, or other digital media in any and all of its publications, including web-based publications and social media, without payment or other consideration.

Participant Signature: _____ Date: _____

Health Information

This form must be completed by every participant prior to the start of a CHA Certification.
For minors, this form must be signed by a parent or legal guardian prior to the start of a CHA Certification.
This form must be submitted to the CHA office for CHA Certifier and Assistant Certifier Recertification.

Name: _____

Address: _____

Date of Birth: _____ Sex: _____ Phone: _____

Medical Release (All CHA Certification and Workshop participants must complete this section.)

Emergency Contact: _____

Home phone: _____ Work phone: _____

If medical care is required in conjunction with any CHA activity, and normal permission is not available in a timely manner, the undersigned authorizes appropriate medical care as deemed necessary by emergency medical personnel, a physician, or the medical facility providing treatment.

_____
Signature of Certification/Workshop Participant Date

As parent or legal guardian of the above named minor, please attempt to contact me at the time of an accident or illness without postponing medical treatment. ***Special Instructions:*** _____

_____

_____
Signature of Parent or Legal Guardian Date

General Health Information And Medical History

Name of family physician: _____ Phone: _____

Date last seen by physician: _____ Reason: _____

_____

CHA events take place out in the open, possibly in an enclosed arena, in a stable area, and in other enclosed structures. They take place on and around horses. Exposure to other animals, insects, plants, and weather conditions is possible. Do you have any known allergies (such as animal, food, insects, or others) and/or health conditions (such as asthma, heart problems, high blood pressure, or others) that might be affected by your participation in these activities?

■ No ■ Yes If yes, please specify: _____

_____

_____

Continued on reverse side ⇨

IMPORTANT: Your answer of "yes" to the previous question also reflects that you are not relying upon CHA, the facility provider, the certifiers, their assistants or agents, and/or others acting on their behalf to prevent or reduce your exposure to any of these conditions before, during, or after the CHA event. Although CHA continually strives for and promotes safety in equine activities, you are solely responsible for your own health and safety at all times. Please bring with you and always be prepared to self-administer your own medications. You are strongly encouraged to wear a visible "Medic-Alert" bracelet or necklace during the activities.

Are you current on your immunizations or boosters for Tetanus? ■ Yes ■ No

Are you currently taking any medications? If "yes," please list (including insulin.) ■ No ■ Yes

Medication: _____ Used for: _____

When taken: _____

Medication: _____ Used for: _____

When taken: _____

Medication: _____ Used for: _____

When taken: _____

Has your regular physician, or the specialist who is presently treating, you expressed concerns about you riding or being near horses or engaging in the type of activities for which you are completing this CHA form?

■ No ■ Yes If "yes," please attach a statement from your physician allowing your participation in these activities.

Do you have any physical and/or mental health conditions, problems, and/or disabilities, which may affect your ability to safely ride a horse or participate in the activities for which you are completing this form?

■ No ■ Yes If "yes," please specify: _____

_____

_____

In the past 5 years have you had any activity restriction from horseback riding or participation in the activities for which you have completed this form?

■ No ■ Yes If "yes," please specify: _____

_____

_____

Do you presently have any activity restrictions for safely riding a horse or participating in the activities for which you are completing this form?

■ No ■ Yes If "yes," please attach a statement from your physician indicating the nature of your activity restriction and the prognosis for future restriction.

I have completed the above information to the best of my knowledge and will assume the responsibility for my own health and safety during any CHA activity in which I am involved.

_____

Signature Date

_____

Signature of Parent or Legal Guardian Date