



## RIDING PROGRAM QUESTIONNAIRE

Rider's Name \_\_\_\_\_ age \_\_\_\_\_

How many years riding? \_\_\_\_\_

Have you ridden recently? \_\_\_\_\_

Do you ride on a regular basis? \_\_\_\_\_

Do you currently take lessons? \_\_\_\_\_

Circle all skills you are capable of as a rider:

Walk

Trot

Canter

Jump

**Please email your answers on this form as soon as possible to [dmoore@knoxschool.org](mailto:dmoore@knoxschool.org) so we may pair the appropriate riders and horses.**

**You may also fax the form to 631-686-1652.**



## THE KNOX SCHOOL RIDING PROGRAM RELEASE AND CONSENT AGREEMENT

We, the parents or legal guardians of \_\_\_\_\_, a minor (the "child"), acknowledge his/her intention to participate in a horseback riding program conducted at The Knox School, Inc. (the "School") utilizing horses, personnel and facilities both at the School and off campus. We hereby agree to pay for all fees associated with the child's participation in the riding program in accordance with the rates established by the School, which are hereby incorporated into the Release and Consent Agreement.

We further acknowledge that horseback riding is an inherently dangerous activity which can result in personal injury and property damage, and that by participating in the riding program the child is subjecting himself/herself to risk of same. In consideration of the child being permitted to participate in the program for a fee, we hereby, for himself/herself and ourselves, and for his/her and our executors, administrators, heirs and assigns, release and discharge the School, its Trustees, officers, servants and employees from any and all claims, demands, rights and causes of action, for whatsoever kind or nature, for personal injury or damage to property and consequences thereof, arising out of the child's participation in the riding program.

Further, in the event that the child is injured while participating in the program, we hereby consent to treatment by the nurse(s) of the School, and to his/her transfer to any hospital in the event of a medical emergency. We hereby authorize a representative of the School to consent on our behalf to any emergency medical treatment to be rendered to the child. The School will make reasonable attempts to contact us in advance of such emergency treatment, provided medical circumstances permit. We understand that we will be financially responsible for the costs of any such medical treatment.

\_\_\_\_\_  
Parent or Guardian Signature  
Printed name: \_\_\_\_\_  
Telephone #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Health Ins Co: \_\_\_\_\_

\_\_\_\_\_  
Parent or Guardian Signature  
Printed name: \_\_\_\_\_  
Telephone #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Group #: \_\_\_\_\_

Please provide a copy of your insurance card. Photocopies of the Release and Consent Agreement shall have the same legal effect as the original.