



Clinic:			
Participant's Name:		Date of Birth:	
Participants's Level of Experience: <input type="checkbox"/> No Experience <input type="checkbox"/> Beginner <input type="checkbox"/> Intermediate <input type="checkbox"/> Advanced			
Please Briefly Describe Experience:			
Parent or Guardian Information			
Name:		Address:	
City:		Province:	Postal Code:
Home Phone:	Work Phone:		Cell Phone:
Place of Employment:			
Parent or Guardian Information			
Name:		Address:	
City:		Province:	Postal Code:
Home Phone:	Work Phone:		Cell Phone:
Place of Employment:			
Emergency Contact Information			
Contact 1:		Phone 1:	Phone 2:
Contact 2:		Phone 1:	Phone 2:
Health Information			
Health Care #:			
List pre-existing medical conditions:			
List Allergies:			
Provide Any Instructions to Manage Your Child's Health Condition(s)/Symptoms They May Exhibit/Medication Distribution Schedule etc.:			

Day pens are available for rent at a rate of \$15/day for camps and clinics. Please indicate the number of day pens required:



Permission To Obtain Medical Attention:

I/We _____ hereby give Angelique Bjork permission to obtain medical attention for _____ in the event of illness or injury while participating in activities at Sunny Sky Equine.

Signature of Parent(s) or
Guardian

Witness Signature:

Name of Parent/
Guardian:

Name of Witness:

Dated:

Dated: