TAMARACK HILL FARM, INC.

INDIVIDUAL AGREEMENT AND WAIVER OF LIABILITY

WARNING

Under Vermont Law, an equine activity sponsor is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities that are obvious and necessary, pursuant to 12 V.S.A. section 1039.

I understand that the sport of horseback riding and driving is inherently dangerous and that serious injury and death can occur. I understand that participation in equine activities involves necessary risks. I agree that if any injury occurs to me or my horse or to any equipment that I may use or send to use, I will make no claim against Tamarack Hill Farm, Inc. or any of the Officers, Directors, Employees and Volunteers. I further agree to hold Tamarack Hill Farm, Inc., the Officers, Directors, Employees, Volunteers and Landowners free and harmless from any liability, claims, suits or damages of whatsoever kind or nature that may be occasioned by the horses used by me or the negligence of the persons in charge of such horses and I agree to indemnify and hold harmless this organization and individuals against all liability claims, suits and expenses including attorney fees incurred arising out of any injury to any person or damage to any property caused by me, my horses or attendants.

_____ _____
SIGNATURE OF RIDER DATE

_____ _____
SIGNATURE OF HORSE'S OWNER DATE

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

I, _____, of _____
(Camp Participant) (address)

am aware that horseback riding and jumping involved certain inherent dangers of injury. I also am aware that the Dartmouth-Hitchcock Hospital is the nearest health care facility to Tamarack Hill Farm. In the event that I sustain an illness or injury which renders me unable to make or communicate my desire for or permission to receive medical treatment, I hereby authorize the officials to take me to that facility for treatment unless otherwise stipulated below.

I authorize transport to _____
(medical facility)

I also hereby authorize the medical care providers at the health care facility and whomever they may designate as their assistants to perform such emergency treatment and procedures as they deem advisable. I understand that a personal physician must be selected by or on behalf of a patient if hospitalization or further treatment is required.

_____ _____
Signature of Camp Participant Date

RIDER MEDICAL INFORMATION

NAME	DATE OF BIRTH
ALLERGIES	SOCIAL SECURITY #
MEDICATIONS	
Date of most recent Tetanus Toxoid injection	
Is this rider taking any daily medications? Yes _____ No_____ If yes, which?	
Blue Cross/Blue Shield coverage? Yes _____ No _____ If yes, in which state?	
Blue Cross/Blue Shield certificate #	
Other insurance	Other insurance identification #
Subscriber name on insurance	

EMERGENCY CONTACT INFORMATION

NAME	DAY PHONE	EVENING PHONE
RELATIONSHIP		CELL PHONE